Sudden Unexpected Deaths in Infants and Children*(SUDIC) & Acute Life-Threatening Events that remain unexplained and suspicious requiring resuscitation and intensive care / high dependency interventions in Children and has poor prognosis if child survives* (ALTE)

***(Children - Age under 18)**

APRIL 2025

Cheshire East, Cheshire West & Chester, Halton, and Warrington

(For deaths in children who are not normally resident in Cheshire, please also refer to relevant local guidelines where the child is normally resident if possible)

Section 1 – PAN CHESHIRE SUDIC / ALTE DOCUMENTATION PROFORMA (ALTE defined as acute life-threatening event that remains unexplained and suspicious requiring active intervention/resuscitation and intensive care / high dependency admission and has poor prognosis if child survives)

Section 2 – PAN CHESHIRE SUDIC / ALTE GUIDELINES

Section 1 Contents

For details of Bereavement Support Organisations, refer to Appendix 2C

Section 2 Contents

Section 1

Pro-forma for Documentation in Cases of Sudden Unexpected Death in Infants and Children (SUDIC)
&
Acute Life-Threatening Events (ALTE) in Children that remain unexplained and suspicious requiring active intervention/resuscitation and intensive care/high dependency unit admission and has poor prognosis if child survives.

April 2025

Before commencement of documentation

- Read the general principles and refer to detailed guidance in Section 2. The bulk of this guideline applies predominantly to a sudden unexpected child death under 2 years of age but is also applicable to an older child who dies suddenly and unexpectedly. And it is also applicable to cases of ALTE (Acute Life-Threatening Event) that are unexplained and suspicious, requiring active intervention/resuscitation and intensive care/high dependency unit admission, and has poor prognosis if child survives, if deemed reasonable, appropriate, and proportionate by professionals involved. If in doubt, consult with Designated Doctor for Child Deaths. For ease of reading the term infant is used throughout but includes infant or older child. In cases where child safeguarding procedures have been triggerred, initial Joint Agency Review meeting (JAR) may be deferred unless the child has died.

- Take a copy with you when you go to see the parents/carers.

- Check available records that may give you some background information

- While completing the documents if certain sections are not applicable enter NA (not applicable), rather than leaving the section blank; Enter full names, wherever requested, in Capital letters. If completing electronically, double click on the Header to complete patient details

- Parents/carers feel less threatened if certain direct/leading questions are asked as part of the protocol document.

- Seek advice from a senior member of the team if unsure about any section of the guidelines or the documentation process.

- The description should be factual without any interpretation.

- Record the details accurately; Do not use jargon or acronyms.

- For measurement purpose refer to:

Centimetre as	cm
Gram as:	g
Kilogram as:	kg
Millilitres as	ml
Milligrams as:	mg

- For description of time use 24:00h clock if possible. Otherwise, state am/pm clearly and ensure that date is appropriately advanced by +1 after midnight.

GENERAL PRINCIPLES FOR MANAGEMENT

1. Please note, the documentation proforma and the guidance is applicable to SUDIC and ALTE (Acute Life-Threatening Event) cases, in the community or in-hospital, if deemed reasonable, appropriate and proportionate, following discussion with professionals involved with the case and/or Designated Doctor for Child Deaths. ALTE is defined as: Any sudden/unexpected collapse of an infant requiring some form of active intervention/resuscitation and subsequent intensive care/high dependency unit admission and remains unexplained and suspicious, and has poor prognosis if child survives.

2. On receipt of a 999-call indicating that an infant or child has been found unexpectedly collapsed or dead, the call centre should immediately notify ambulance control to dispatch an ambulance crew and, where appropriate, a first responder. The police should also be notified, and an officer dispatched to the scene. This officer should ideally be an appropriate qualified investigator, and every effort should be made for this officer to attend in plain clothes.

3. On arrival at the scene, the first responder or ambulance crew should carry out an immediate appraisal of the circumstances. Unless there are clear indications that the infant has been dead for some time, appropriate resuscitation should be started and continued until the infant is brought to hospital.

4. The paramedic/ambulance crew should inform the emergency department of the hospital that an infant has been found unexpectedly collapsed or dead and to have the resuscitation team on standby, anticipating the arrival of the infant/child.

5. The first responder/ambulance crew should elicit a very brief initial account of the circumstances and whether there are any infant medical issues, such as any relevant past medical history or current medications for the child. They should note their impressions of the environment in which the infant was found, and any concerns about care. A copy of the ambulance crew's record should be provided to the lead health professional and police investigator.

6. Unless there are exceptional reasons not to, the infant should be brought immediately to an emergency department with paediatric care. Resuscitation should be continued en-route to the hospital. The default position should always be to attend the emergency department, but with older children where death has been confirmed and cause obvious (for example, stabbing or a Road Traffic /Train-related accident), a decision may be made to transfer straight to mortuary facilities, or to remain in-situ at the crime scene to allow other forensic processes to take place under the guidance of the senior police investigator. In such cases, it is important still for a named professional to be identified who should take lead responsibility to complete the Immediate Decisions Proforma, and relevant child death notifications etc. and follow due SUDIC procedures. It must still be ensured that SUDIC process has been triggered and bereavement support is in place. Where a health professional has not been involved, Police must complete relevant notifications.

7. Arrangements should be made for the family to attend the emergency department, either accompanying the infant in the ambulance or separately. Consideration should be given to the care and welfare of any other children in the home by attending Police.

8. The attending police investigators should undertake an initial appraisal of the environment where the infant died or was found. This may include brief questioning of the family, but the priority is to get the infant with the family to an emergency department. Police interviewing should not delay this departure. Further priorities are to ensure the safety of others, including other children in the home, and to maintain the integrity of the environment. The police investigators should assist the ambulance crew in these arrangements.

9. If there are signs that the infant is clearly dead and has been for some time, for example, the development of rigor mortis or dependent livido, resuscitation would not be appropriate. This should be discussed with the family. In such circumstances, it will still be appropriate to transfer the infant and family to an emergency department with paediatric facilities where the joint agency response may be initiated, the infant can be examined, and appropriate immediate medical investigations carried out.

10. In the rare event resuscitation is not appropriate and the family requests to spend a short period of time with the infant at home before transfer to hospital, the attending ambulance and police team should liaise with the paediatric team at the hospital and with the police investigating officer, plan an appropriate response. In such circumstances, a GP, certified member of ambulance staff or forensic medical examiner must confirm that the infant has died. The child should subsequently be brought to hospital A & E for due SUDIC procedures to be followed including completion of the Immediate Decisions Proforma. All other aspects of the joint agency response should proceed along the same lines as for any other infant death. Medical investigations that include the removal of samples from the body must take place on HTA-licensed premises.

11. The infant remaining at the home address should be seen as a very rare occurrence, however, and not one to be routinely offered to the family – only when exceptional circumstances exist. If this is a chosen course of action, liaison should also occur with the coroner at the earliest opportunity.

12. If there are immediate indications of abuse, neglect or an assault contributing to the death, the police should take the lead in the management, under the direction of an investigating officer. In such circumstances, and if the infant is clearly dead, it may not be appropriate to move the infant and the scene should be secured as for any potential crime scene.

13. In the emergency department, the care of the family and the investigation of the cause of the death should follow a similar course, whether or not resuscitation has been attempted.

14. The decision to stop resuscitation should be made by a senior medical practitioner (usually the consultant paediatrician or consultant in emergency medicine) after discussion with the resuscitation team and the family.

15. Where an infant is successfully resuscitated, they should be stabilised and moved to a paediatric intensive care facility. Subsequent discussions regarding ongoing intensive care or the withdrawal of care should involve the paediatric intensive care team, the family, and the police investigator. Consideration should be given to the timing of any withdrawal of intensive care, support for the family around the decision, and the appropriate timing and process of the joint agency investigation, including a home visit.

16. Once a decision has been made to stop resuscitation, an appropriately qualified medical practitioner should confirm that the infant is dead, in accordance with established guidelines. Confirmation of the fact of death and the time should be recorded in the infant's notes.

17. When the infant has been pronounced dead, the lead health professional (normally the on-call consultant paediatrician) should inform the family, having first reviewed all the available information. This interview should be in the privacy of an appropriate room. The member of staff allocated to care for the family should also be present at this time.

18. Once death has been confirmed, the consultant paediatrician on-call should carefully and thoroughly examine the infant. The police investigator should ideally be present while this happens. A particular note should be made of any marks, abrasions, rashes, evidence of dehydration or identifiable injuries at this time, in addition to a detailed general examination. The presence of any discolouration of the skin, particularly dependent livido,

should be carefully and accurately documented, along with other post-mortem changes such as frothy blood-stained fluid from the airways and rigor mortis. Where possible, the eyes should be examined by direct fundoscopy for the presence of retinal haemorrhages. All findings should be carefully documented in the notes and on a body chart. The infant should be weighed and measured (length and head circumference), and the measurements plotted on a centile chart. The deceased child should be re-examined where practicable; to note any external marks that might not have been present on initial examination, particularly if trauma is being considered as a possible causative factor in the child's death.

19. If resuscitation has been attempted, any intravenous, intra-arterial, or intra-osseous lines inserted for this purpose should only be removed following discussion with the police or coroner. All medical interventions, including sites of attempted vascular access, should be carefully documented on a body chart. If a cannula has been inserted to drain a suspected air leak in the chest but it is thought that it may have contributed to failed resuscitation (for example, by causing a pneumothorax), it should not be removed.

20. If an endotracheal tube has been inserted, this may be removed after its correct placement in the trachea has been confirmed by direct laryngoscopy (preferably by someone other than the person who inserted it) and the case discussed with the police or coroner. The size and position of the tube should be documented.

21. Once the infant has been examined and all findings recorded, along with medical or police photographs where indicated, and samples taken, the infant can be cleaned and dressed and given to the family to hold if they wish, unless there are suspicious findings that preclude such actions. If they wish, the family should be offered the option of cleaning and dressing their infant in an appropriate setting. This may be particularly important in certain cultures.

22. Health staff in the emergency department should offer the family the option of mementos being taken such as handprints, footprints, a lock of hair and photographs. This should be done sensitively, recognising that this can be important for many families but may not be wanted by all. If there are suspicious circumstances surrounding the death, the taking of mementos should be discussed with the investigating officer to ensure this does not interfere with any investigation; in such circumstances, it may be appropriate to delay this until after the post-mortem examination.

23. All staff should follow the general principles of family support.

24. The consultant paediatrician or senior medical practitioner should ensure that the joint agency response is triggered by informing the police, if not already involved, and children's social care. The Designated Doctor for Child Deaths and Specialist nurse (depending on local arrangements) should be informed at the earliest possibility, to decide the timing of the JAR meeting.

25. The lead health professional (consultant paediatrician on-call/senior medical practitioner) should take a detailed and careful history from the family, alongside the police investigator where possible, to avoid the need for repeated questioning.

26. Where there are any suspicious circumstances surrounding the infant's death, it may be necessary for the police to interview separately the infant's parents or primary carers at the time of death. In such circumstances, it is still important to obtain a full and careful medical history. A coordinated plan of who talks to the family and when should be agreed between the senior police investigator and the lead health professional. In some cases, the police investigator may also request voluntary blood and/or urine samples from family members if they think alcohol or drugs may be a contributory factor.

27. The history should include a careful review of the past medical history, including pregnancy and birth, the infant's growth and development, any relevant social and family history, and the events leading up to and following the discovery of the infant's collapse. (See Section 1B). It is important that, as far as possible, the family's account of events should be recorded verbatim.

28. The Personal Child Health Record ('Red Book') may be an important source of information. The police may have removed it or it can be accessed at the home visit, if one is planned. Relevant family history, birth details, immunisation status, growth trajectory, outcome from routine reviews etc. may be found in it.

29. The information obtained from these sources, including the ambulance record (section 4 above) should be recorded on a standard SUDIC pro-forma, commenced in hospital, and taken to the home visit if one is planned.

30. History taking is an ongoing process and should be carefully recorded and shared with the lead professionals. Any gaps can be covered in later meetings with family.

31. In general, investigations are undertaken by the pathologist during post-mortem exam. Whilst it may not be mandatory for clinicians to undertake any investigations listed below post death, if PM exam likely to be delayed or under exceptional circumstances, it may be necessary to obtain samples at the earliest. Also, various medical investigations may be initiated, including blood samples for electrolytes and blood cultures during resuscitation. If these have not been obtained during resuscitation, they should be obtained post-death, especially investigations for metabolic disorders, sepsis to reduce false positives if delayed, and blood sample to be stored for Whole Genome Sequencing (WGS) studies, following discussion with the Coroner. In fact, it is now generally recommended for a blood sample to always be obtained for Culture, Metabolic studies and Whole Genome Sequencing (WGS) Studies as soon as possible post death. Any samples collected post-mortem must be taken from the body on HTA-licensed premises. The police investigator should arrange for appropriate documentation and transportation. Coroner must be consulted prior to collecting postmortem samples and any samples collected are the property of the Coroner.

32. A single attempt at a femoral or cardiac aspiration could be made by a competent practitioner. Repeated attempts should be avoided as they may compromise the integrity of the cardiac anatomy. Blood samples should ideally be taken from a venous or arterial site, such as the femoral vein rather than cardiac puncture, and should be avoided in potential forensic cases.

33. A single attempt at urethral catheterisation or supra-pubic aspiration could be made and, if urine is obtained, it should be sent for microscopy and culture, metabolic investigations and toxicology as outlined in Section 1D.

34. A single attempt at a lumbar puncture could be made and, if cerebro-spinal fluid is obtained, a sample sent for microscopy and culture. If sufficient amount of CSF available, a sample should be frozen for future metabolic investigation.

35. Any stool or urine passed by the infant, together with any gastric or nasopharyngeal aspirate obtained, should be carefully labelled and frozen after samples have been sent for bacterial culture and for virology. If the nappy is wet or soiled, it should be removed, labelled and frozen.

36. The lead health professional could arrange for a full radiological skeletal survey or other appropriate imaging to be undertaken, if required and feasible, but this is generally undertaken by Paediatric Pathologist at postmortem exam. If performed locally, it should be reported by an experienced paediatric radiologist prior to the post- mortem examination

being commenced. For children over 24 months, if in doubt, the need for such imaging should be discussed with the Designated Doctor for Child Deaths. Imaging investigations should be reported on as soon as possible in order to identify or rule out bony injuries, as this may change the focus of the investigation.

37. Details of the recommended samples to be taken and the purposes for which they are intended are listed in Section 1D. All investigations are generally undertaken at the postmortem examination by the Pathologists. Although it is essential that samples for various metabolic tests are obtained as soon as possible after death, including samples for microbiology and toxicology, evidence does not suggest clear differences in yield between samples obtained in the emergency department and those obtained at post-mortem examination. However, if postmortem examination is likely to be unduly delayed, it may be worthwhile collecting the samples at the earliest by the attending clinician.

38. In sudden unexpected infant deaths, a detailed fundal examination should be undertaken by a suitably qualified and experienced Paediatric Ophthalmologist at the earliest, where possible. If access to Paediatric Ophthalmology expertise is not available at the presenting hospital, a paediatrician could undertake the fundal exam, and document any limitations in expertise. Fundal exam may still be undertaken as part of post-mortem histopathological examination.

39. The lead health professional / key worker should ensure that all relevant professionals and organisations are informed of the infant's death, including the coroner, the GP and health visitor or midwife, the child health computer system and the local CDOP.

40. A careful account of the resuscitation should be recorded in the infant's notes, including the methods used, duration and personnel involved. The history and examination findings should be carefully documented. All actions taken following the death should be documented in the infant's notes, along with details of information shared with the family and with other professionals.

41. Please note, all the above principles are applicable to both community and in-hospital cases of ALTE or deaths, in a child or young person under 18 years of age, as relevant.

Child/Hospital Details			
Childs Name:		Date of Birth	
Hospital Number:		Date of death and time:	
Hospital Name:		Place of death e.g., ED/Other (Specify)	

PROFORMA FOR SUDDEN UNEXPECTED DEATH IN CHILDREN (SUDIC) / ACUTE LIFE-THREATENING EVENT (ALTE)

SECTION 1A: EMERGENCY DEPARTMENT ARRIVAL AND RESUSCITATION RECORD

(To be completed by the A&E Consultant/Duty Consultant Paediatrician depending on who leads the resuscitation)

Name and Designation of Doctor completing:		**Signature:**	
Name of ED Resuscitation Nurse:		**Signature:**	
Date:		**Time:**	
GP Name & Address:			
Consultant Paediatrician:			
A&E Consultant:			
A&E Nurse:			
Paediatric Nurse:			
Police Lead Investigator and Contact Details:			
Social Worker and Contact Details:			

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Coroner/Coroner's Officer:	
Other Professional involved and their Contact Details:	
Date / time when the child was found dead or collapsed:	

Any other relevant information:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Date / time when ambulance/police were informed:	
Who called the ambulance?	
Arrival of Ambulance Team at the Scene	
Time ambulance team arrived at the scene:	
Condition of the infant as reported by the ambulance team:	

	YES	**NO**
Did the parents/carers undertake resuscitation?		
Did the child show any signs of life?		
Did the child show signs of rigor mortis?		
Did the child show signs of postmortem lividity?		
What was the room temperature?		
What was the child's temperature?		
Was resuscitation carried out by the ambulance team? If yes, was		
- External cardiac massage given?		
- Bag and mask ventilation?		
- Oxygen by mask?		
- Endotracheal intubation undertaken?		
- Were any drugs given?		
(If yes to drugs, please specify name and the dose):		
Were any intravenous fluids given?		
(If yes to intravenous fluids, please specify name and volume):		

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Did the team observe any signs of parental / carer alcohol use? (If yes to intoxication, please give details):		
Any other observations by the ambulance team, including any suspicious circumstances:		
Arrival in the Emergency Department		
Time of arrival in the ED:		
Condition of the child upon arrival, including rectal temperature:		
	Yes	**No**
Was there any sign of life? (If no, complete below)		
Did the child show signs of rigor mortis?		
Did the child show signs of postmortem lividity?		

Any other comments:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

DETAILS OF RESUSCITATION IN EMERGENCY DEPARTMENT

(To be completed by the A&E Consultant/Duty Consultant Paediatrician depending on who leads the resuscitation)

	YES	NO
Was resuscitation undertaken (in ED)?		
Did the child show any signs of life?		
- External Cardiac Massage given?		
- Endotracheal Intubation (Type and Size):		
- Time of intubation:		
- Who intubated the child?		
- Assisted ventilation with bag and mask?		
- Assisted ventilation with the endotracheal tube?		
- Defibrillation?		

Time of first vascular access:	
Type of vascular access (venous/introsseus)	
Intravenous fluids given (Name and volume given):	
Drugs given (name and dose):	
Chest drain/pericardial tap/other procedures (specify):	
Total duration of the resuscitation:	
Time death declared:	

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Doctor pronouncing life extinct:	
Time when parents informed*:	
Names and Designation of all present at Resuscitation:	
*(*This should always be done by the senior clinician, ideally A&E Consultant or Duty Consultant Paediatrician)*	

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

List all drugs used; Document direct observation of position of endotracheal tube prior to removal; Document any cannulae, chest drains, nasogastric tubes or any other medical interventions carried out, prior to removal.

(The Emergency Department Resuscitation sheets will be completed by the A & E Consultant or Duty Consultant Paediatrician, depending on who leads the resuscitation)

Child/Hospital Details			
Childs Name:		Date of Birth	
Hospital Number:		Date of death and time:	
Hospital Name:		Place of death e.g., ED/Other (Specify)	

INVESTIGATIONS AND TESTS TAKEN AT RESUSCITATION

(To be completed by A&E Consultant / Duty Consultant Paediatrician. The ED Nurse responsible for resuscitation documentation should keep a log of all investigations undertaken during the resuscitation)

Type of Test	Date & Time	Results	Tick if pending
Blood			
Urine			
Stool			
CSF			
Swab			
X-Ray			
CT scan			
MRI scan			
Photographs			
Others			

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Any other comments:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

SECTION 1B - HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Name and Designation of Doctor completing:		**Signature:**	
Date:		**Time:**	

Circumstances of the Event	
Source of Information:	
Name of Parent(s) / Carer(s)	**Relationship to Child**
Parental Consanguinity? If yes, indicate degree (1st, 2nd etc.) of consanguinity.	
Date & Time when the child was found collapsed/dead:	
Name of the person who found the child collapsed/dead:	
Was it at home or at another place?	
If other than home, state the address:	
Which room of the House: *(Child's own bedroom/parental bedroom/other-please specify)*	
Where was the child found? *(Parental bed/cot/basket/sofa/other-please specify)*	
If parental bed, who was with the infant?	
If parental bed, what was the size *(single/double?)*	
What was the condition of the child when found by carer?	
What position was the child found? *(Prone/Supine/other-please specify)*	

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Was the baby's face covered with blankets or any other clothing?	
Did the child's mouth or nose appear blocked? *(If yes, please give details)*	
Was there any evidence of vomiting? *(If yes, please give details)*	
Was there any evidence of bleeding? If so, describe *(site, fresh whole blood/ serosanguinous/blood clots)*	
What made the carer see to the child? *(Feeding time/nappy change/ crying/too quiet/interval since previous contact/other- please specify)*	
Was the child on an apnoea alarm monitor? *(Should the infant/child be in an apnoea alarm monitor)*	
What time was the child last seen alive?	
Who was the person who last saw the child alive?	
What was the reason for attending to the child? (Feeding/changing, etc., please specify)	
What was the condition of the child?	
Who were the persons who looked after the child in the last twelve hours?	

Child/Hospital Details			
Childs Name:		Date of Birth	
Hospital Number:		Date of death and time:	
Hospital Name:		Place of death e.g., ED/Other (Specify)	

History of events immediately preceding the collapse/death (record verbatim)

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

EVENTS IN THE LAST 72 HOURS				
How was the infant/child fed? Breast or Formula? (Name):				
Feeding pattern	**Type**	**Volume**	**Frequency**	**Additives**
What age was the infant weaned and what was the current feeding regime?				
What time did the child have the last meal (in older child)?				
Did the child appear ill or unwell during the last 72 hours? *(If yes, please give details)*				
Was the child feeding poorly? *(If yes, please give details)*				
Did the child cry persistently or have poor sleep? *(If yes, please give details)*				

Last Medical Attention	**Date**	**Reason**
Health Visitor		
GP / Reason		
Emergency Department		
Any injury for which no medical attention was sought? *(If yes, please give details)*		

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Child's Past Medical History			
Place of Birth:		Mode of Delivery:	
Gestation:		Birth Weight:	
APGAR Score/ Any Resuscitation at birth:			

	YES	**NO**
Did the infant require admission to the neonatal unit?		
(If Yes to the above question, please give details)		
Was the developmental progress normal? Any seizures in the past?		
If issues with developmental progress or h/o seizures, please give details.		
Was the child thriving and showing normal growth?		
(If No to the above question, please give details)		
Was the child's immunisations up to date?		
In Infant deaths, did Mum receive Pertussis vaccination antenatally?		
Any known allergies?		

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Details of School attended and performance (if school aged child); Include Educational history; Any issues at school? Any behavioural problems:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Any other comments:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Family History **Complete for all adults in the house e.g., mother, father, current partner, other adults in the house e.g., grandparents, daytime carer, or other household resident**				
	Adult 1	Adult 2	Adult 3	Adult 4
Name				
Relationship				
Date of Birth & Age				
Occupation				
Smoking (per day)				
Epilepsy (Y/N) *(If Yes, give details)*				
Sudden Adult Deaths (SAD) *(If Yes, give details)*				
Sudden Unexpected Death in Children *(If Yes, give details)*				
Mental Health Issues (Y/N) *(If Yes, give details)*				
Domestic Abuse/Violence (Y/N) *(If Yes, give details)*				

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Family History (contd.) **Complete for all adults in the house Eg. mother, father, current partner, other adults in the house e.g. grandparents, day time carer or other household resident**				
	Adult 1	Adult 2	Adult 3	Adult 4
Convictions (Y/N) *(If Yes, give details)*				
Alcohol *(amount, type and when last taken)*				
Any Recreational Drug use *(Name and time when last taken)*				
Other (Please state) *(Epilepsy, diabetes, severe learning disabilities, cerebral palsy, etc.)*				
Any prescription drugs				
Anyone with Sensorineural deafness				

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Anyone with history of syncope with exertion / emotion				

Any other comments:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

FAMILY HISTORY - SIBLINGS			
Siblings:			
Name	**Date of Birth**	**Gender**	**School / Nursery Name & Address, if applicable**

Sibling History:						
Name & DOB	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5	Sibling 6
SIDS (Sudden Infant Death Syndrome)						
ALTE						
Seizure Disorder						
Medical condition						
Psychiatric Illness						
Substance Abuse						

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Sibling History						
Name and DOB	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5	Sibling 6
Previous Non- Accidental Injury						
Currently or previously Subject to a Child Protection Plan						
Behavioural Disorder						
Violence						
Any prescription medications being taken? If so, include name of medications and time taken;						
Anyone with Sensorineural deafness?						
Anyone with history of syncope with exertion / emotion						

Any other relevant history regarding siblings:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Any other comments:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

PROFORMA FOR SUDDEN UNEXPECTED DEATH IN CHILDREN

SECTION 1C - PHYSICAL EXAMINATION RECORD

(To be completed by the Duty Consultant Paediatrician)

	Please give details		
Weight (kg):		Temp. on arrival:	
Length:			
Head Circumference (cm):			
Ophthalmic Examination: *(Contact Ophthalmologist, if required)*			
Pre-intubation Mouth Examination: *(Any injury to frenulum of lips/tongue)*			
ENT and Fundal Examination:			
Any genital injuries:			
Site and Type of Medical Intervention:			
Any Visible Bleeding or Discharge from anywhere:			
Photographs Required:			

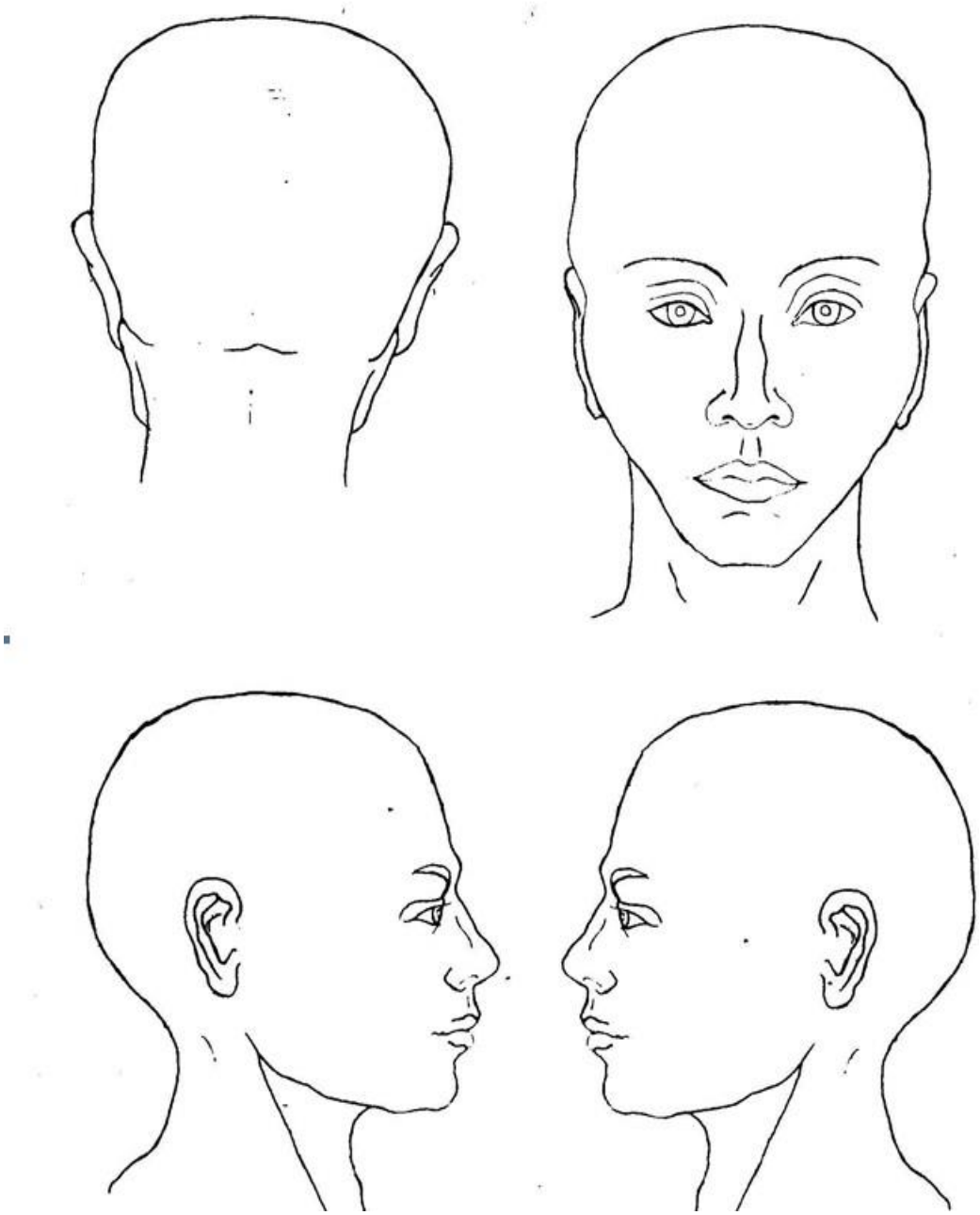
Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

(Detective Inspector to arrange) - Facial - Upper body - Entire body front - Entire body back	
Examination of Musculoskeletal System: Spine, Skull, Chest, Upper and Lower Limbs	
Describe and measure any visible bruises, lacerations, or signs of injury: *(Label the injuries and mark in body diagrams in pages)*	
Observations About Parent(s) /Carer (s)	
Were there any inconsistencies in the history? If so, give details:	
Did parent(s)/carer(s) appear under the influence of alcohol? If so, give details:	
Any other observations?	

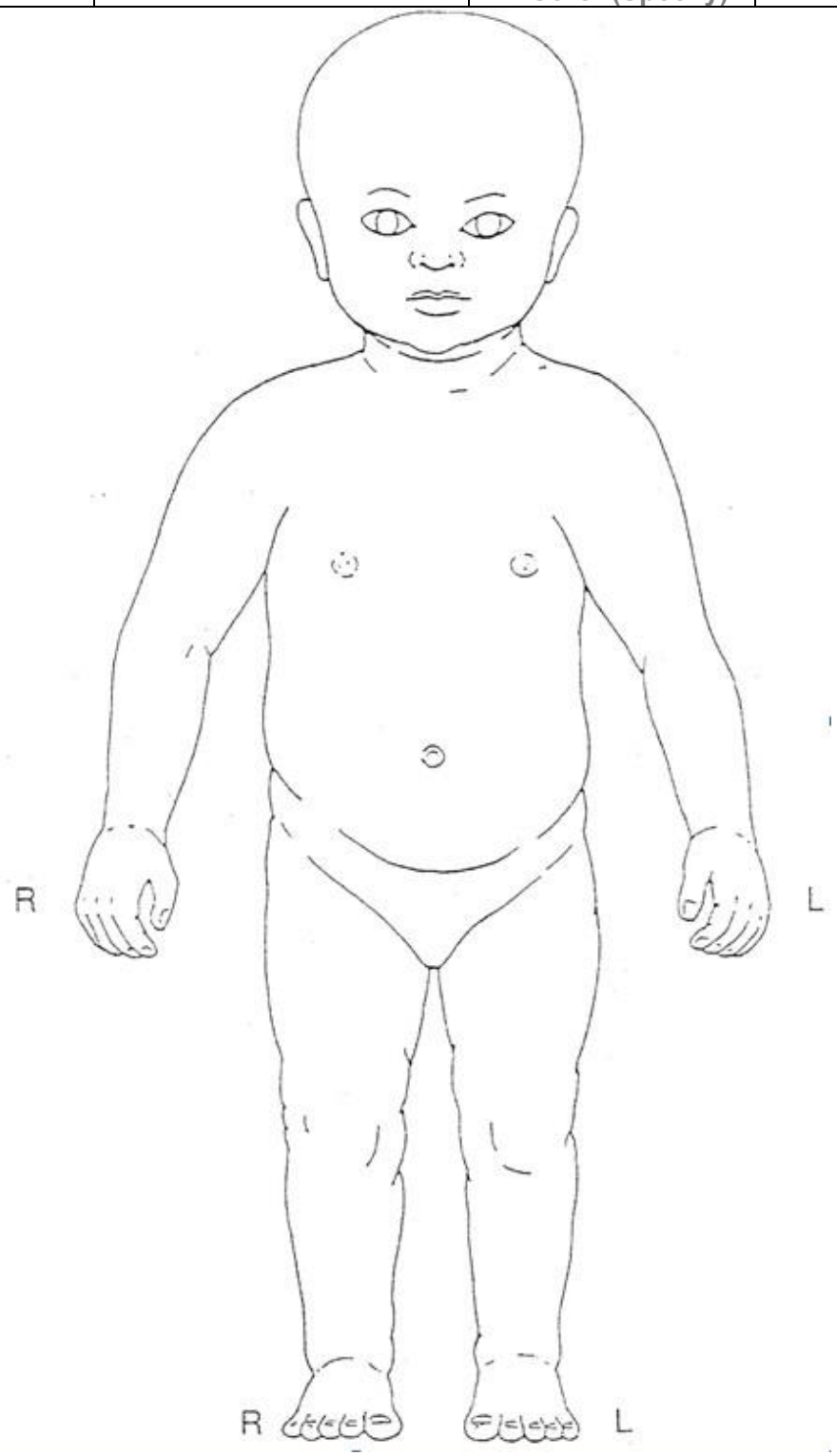
Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Any other comments:

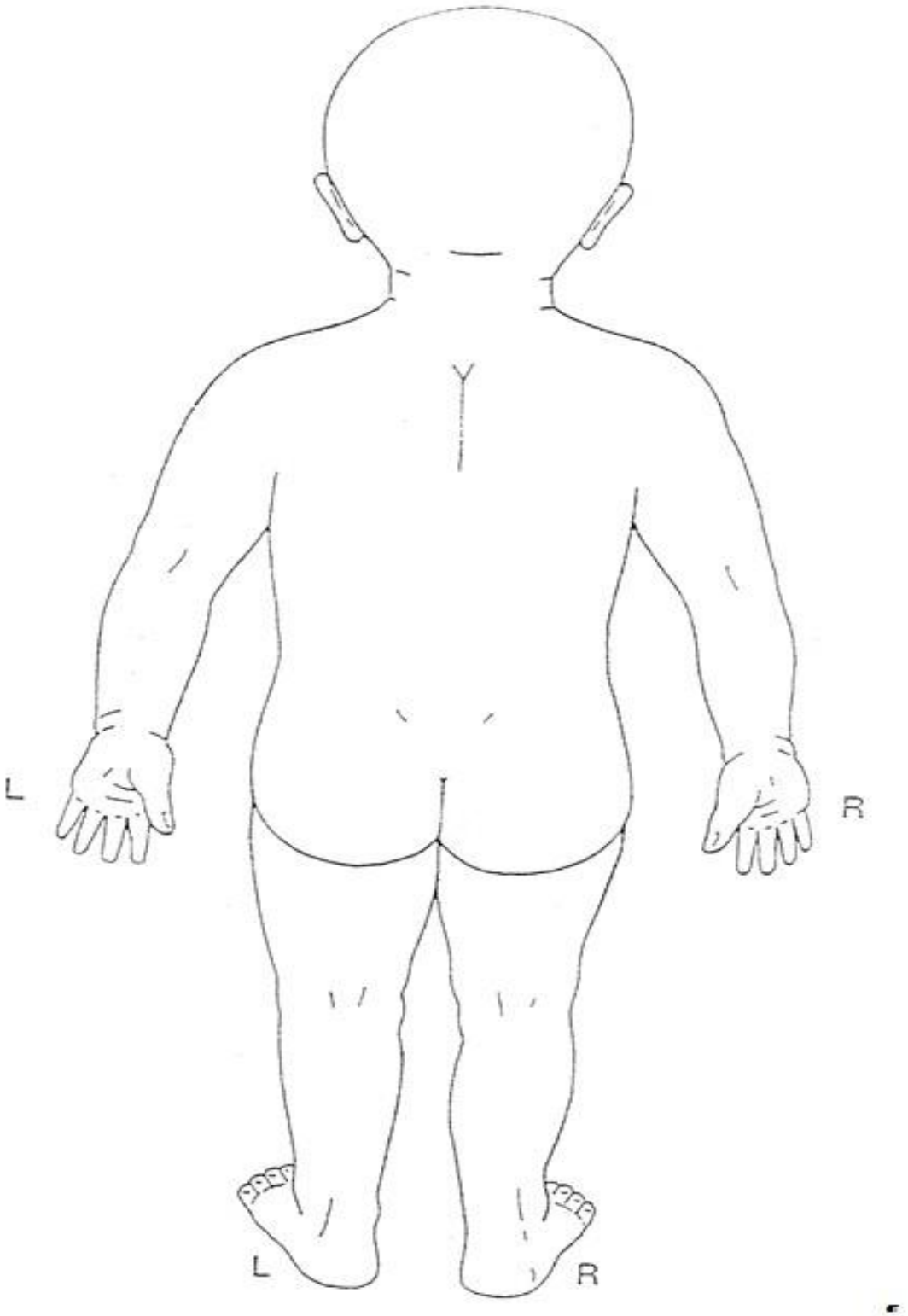
Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	



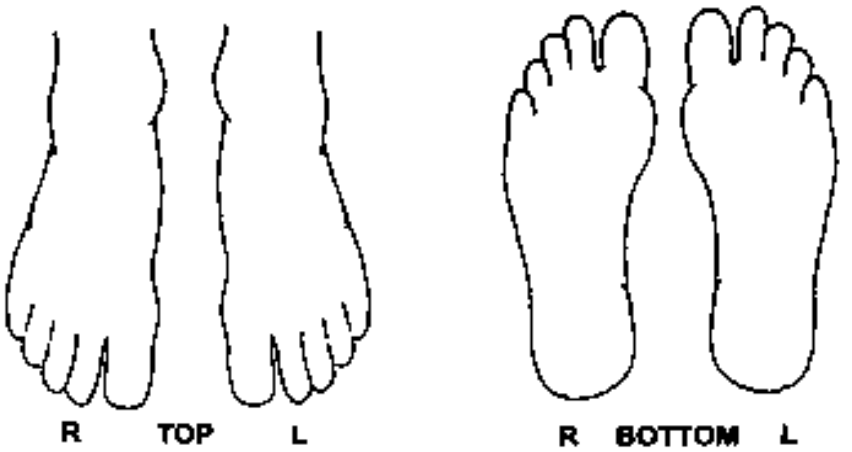
Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

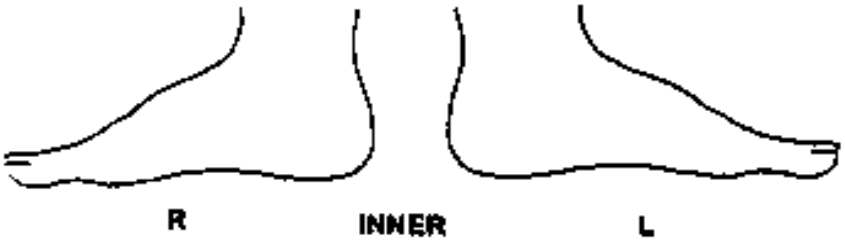


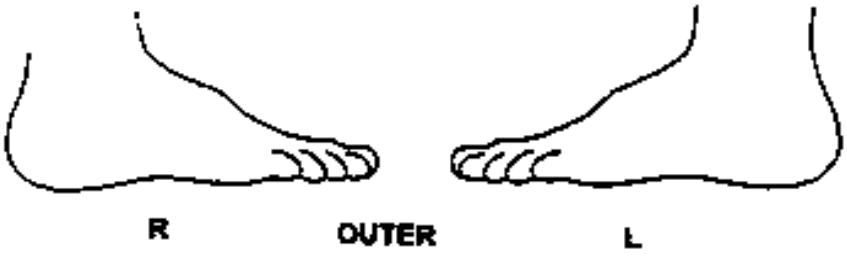
Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	



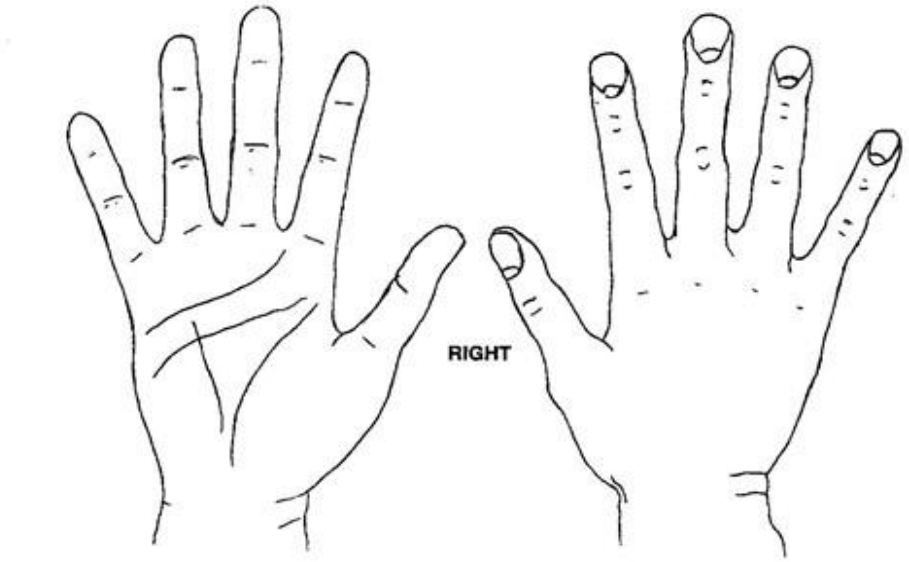
Child/Hospital Details			
Childs Name:		Date of Birth	
Hospital Number:		Date of death and time:	
Hospital Name:		Place of death e.g., ED/Other (Specify)	

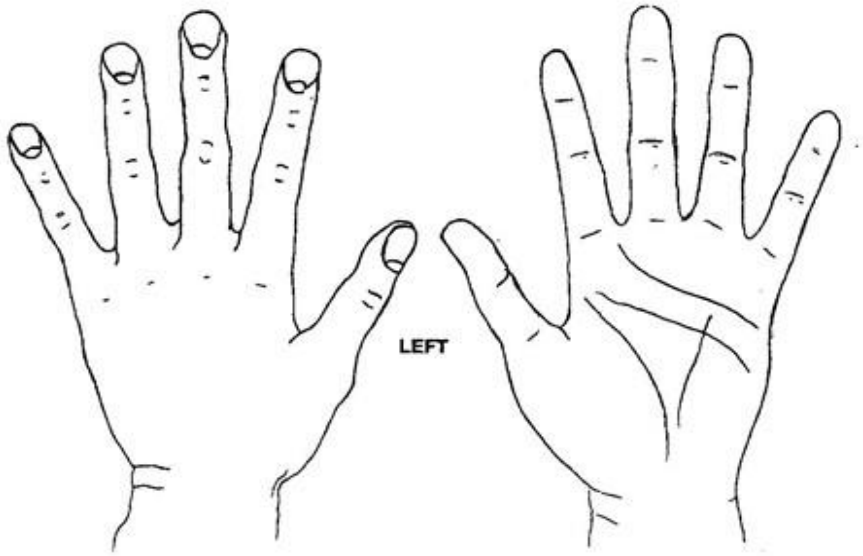




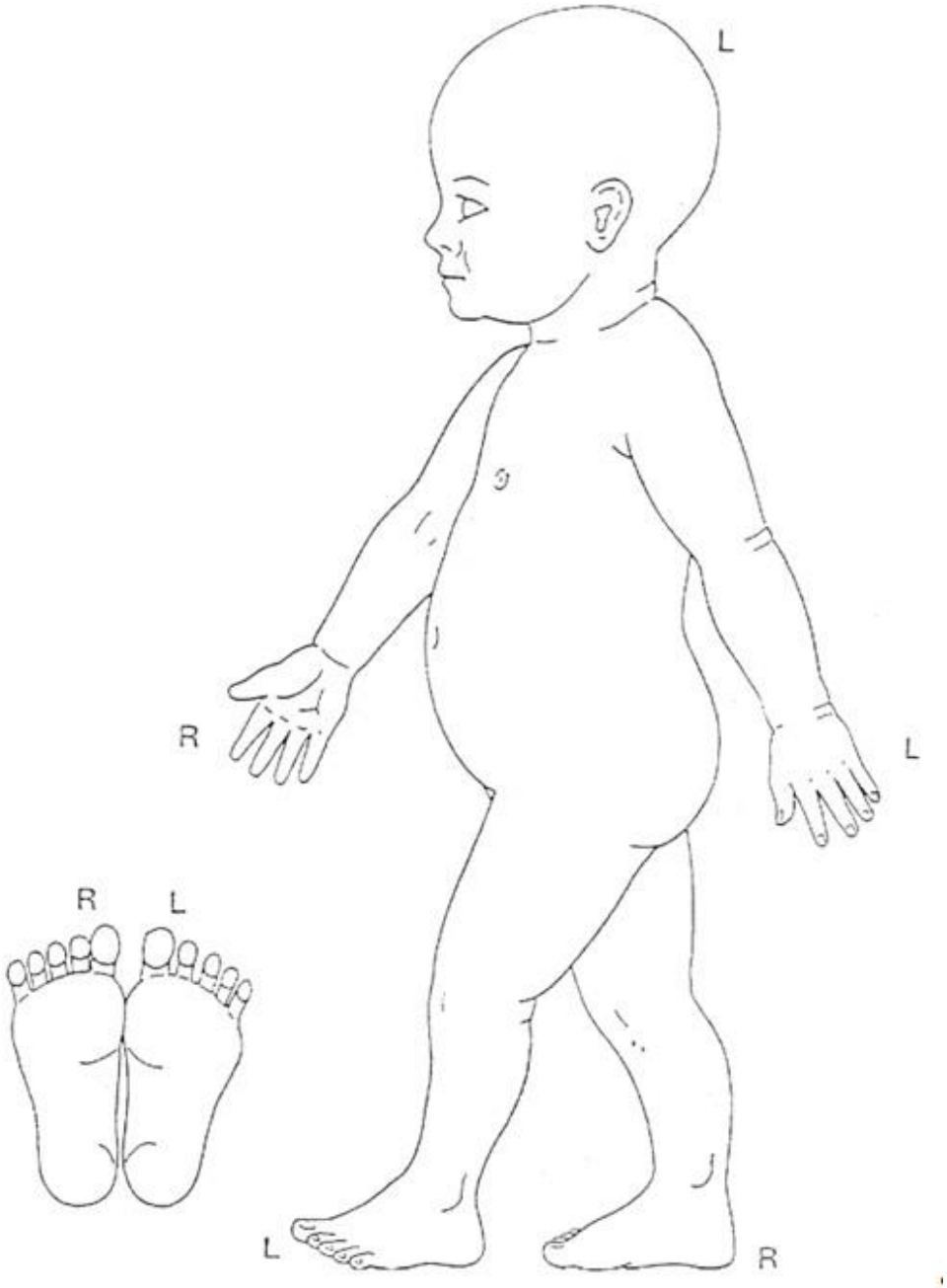


Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

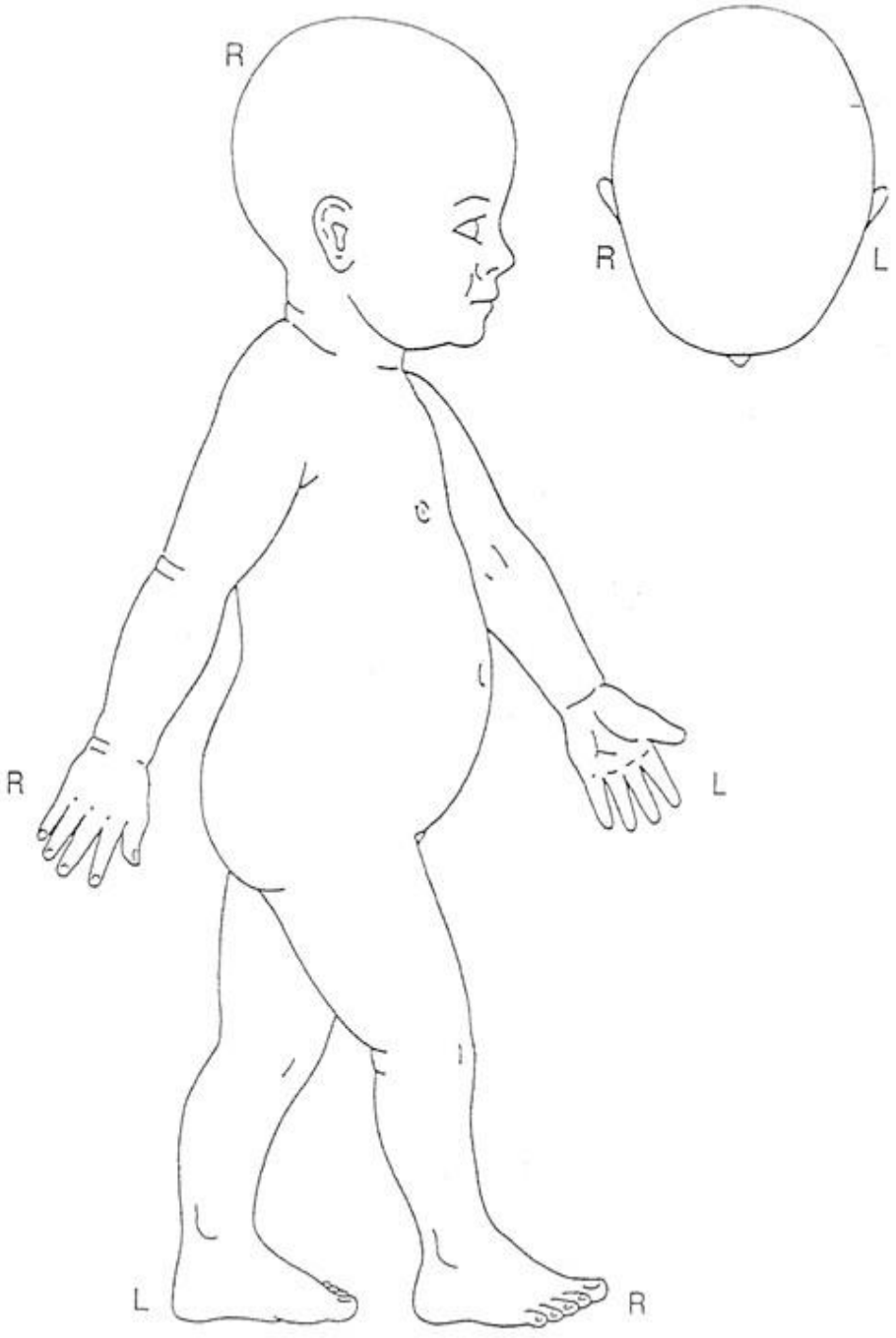




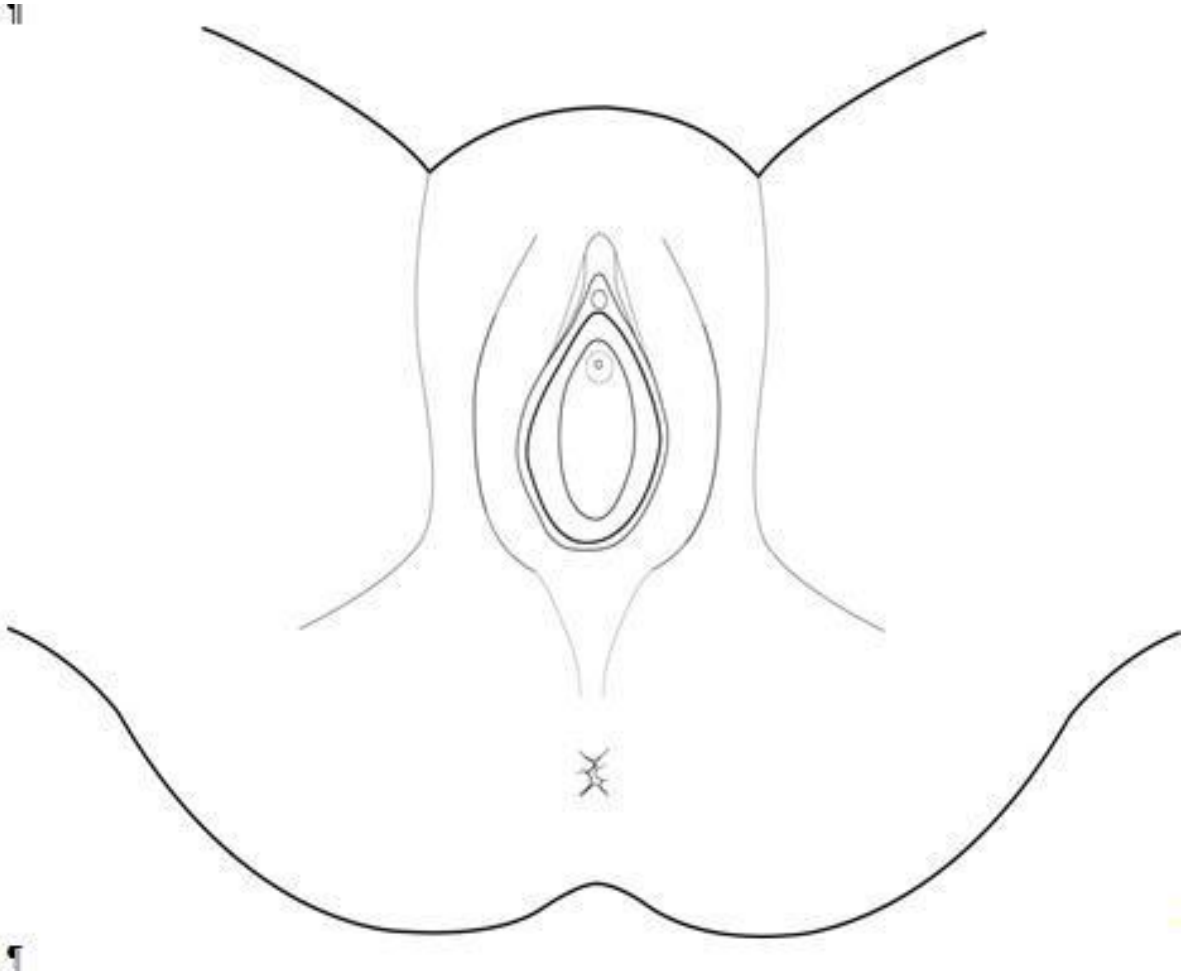
Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	



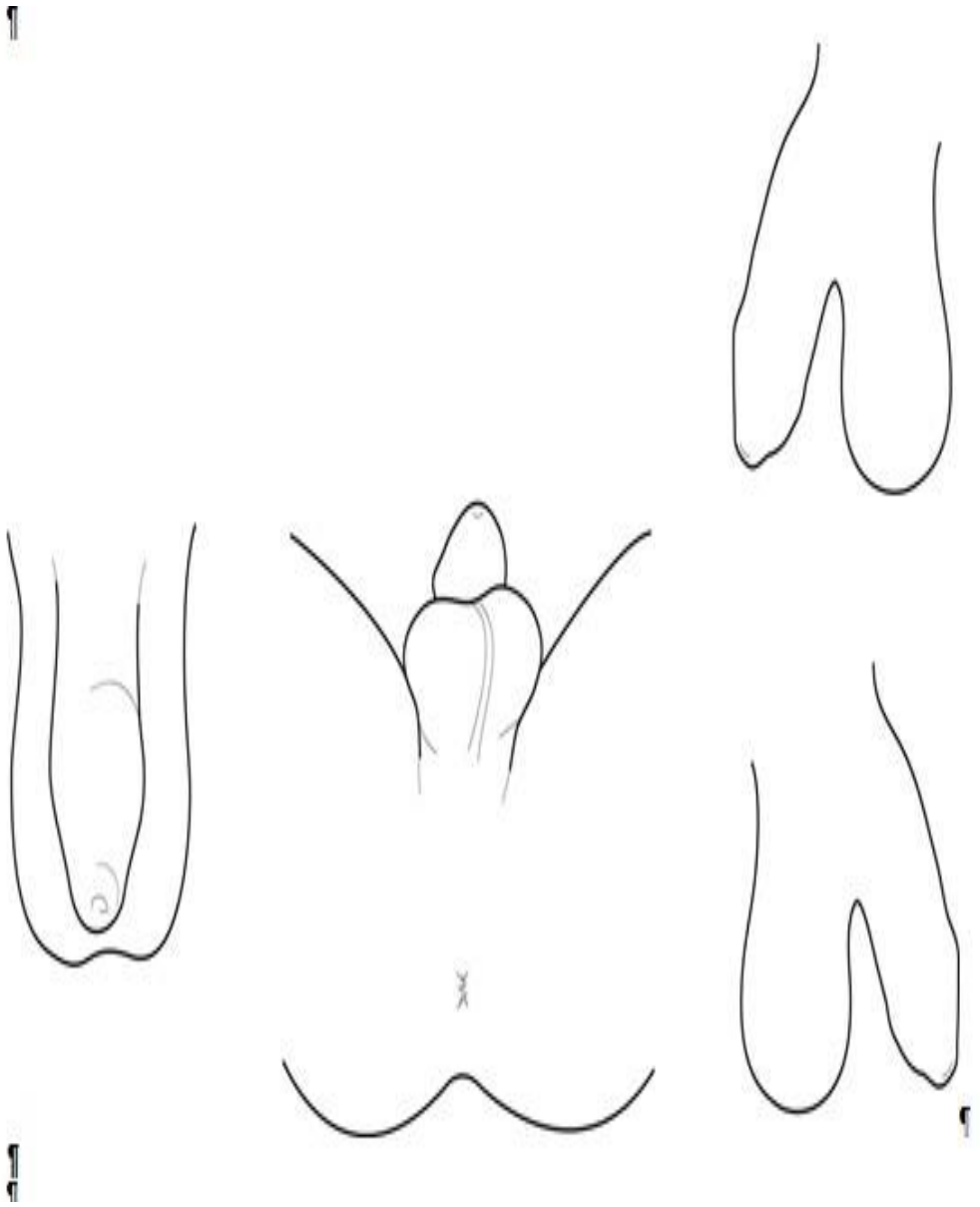
Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	



Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	



Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	



Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Clinical impression of Cause of Death:

Signature:

Name:

Date:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Any other comments:

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

SECTION 1D: COLLECTING POSTMORTEM SAMPLES

1. It is advisable to obtain specimens for metabolic studies, culture and DNA extraction and storage as soon as possible post death. All other investigations listed below will generally be undertaken at postmortem by pathologist. But if for any reason, the postmortem exam cannot be undertaken in a timely manner, it is even more important for various pathology samples and investigations (see the list below) to be undertaken by attending clinician, to avoid later bacterial contamination and enhance the yield from the tests.

2. Please discuss with the Coroner and/or the Pathologist before taking any samples or undertaking any further investigations post-mortem.

3. All pathology samples must be collected in respective collecting media and appropriately labelled with the child's name, hospital number date and time and duly signed.

4. A record must be made of all samples taken and documented in the notes.

5. Appropriate laboratory requisition forms must be filled in if the samples are being sent to the local laboratory.

6. If the samples are being collected to accompany the body (as per advice of the Coroner or the Pathologist), these samples must be labelled and sealed in specially designed police bags and handed over to the police.

7. Discuss with the Coroner and the Radiologist if non-accidental injury is suspected and immediate skeletal survey or other imaging is required.

8. Discuss with the Detective Inspector if any photography is required.

Blood culture: Aerobic & Anaerobic cultures

Blood: Viral studies (5ml clotted blood)

Blood chemistry Neonatal screening blood test card (5ml Lithium Heparin) for
Hb CO (Carboxy Haemoglobin)
MetHb (Methaemoglobin)
Liver function tests
Amino acids*
MCAD (Medium Chain Acyl-CoA-dehydrogense) *

Blood: drug assay (5ml clotted) *
(Opiates, Benzodiazepines, Alcohol, Salicylates, Paracetamol)

Blood: EDTA sample 2ml for metabolic screen (Organic & Fatty acids)* and storage for DNA studies. Inform parents that DNA studies to identify cause of death would not be undertaken immediately. Genetics team would get in touch to obtain Informed Consent for Whole Genome Sequence (R441) studies, only in cases where post mortem examination does not identify a cause of death and/or criteria for genetic testing is met.

Urine sample (Suprapubic aspiration) for Infection, Drug assay, acyl-carnitine, MCAD, Carnitine assay, Organic and Amino acids

Swab visible blood before cleaning

Photographs for postmortem: Specific photograph for suspected injuries or external anomaly(ies)

Skeletal survey before postmortem: (AP and lateral views) Independent check for ETT localisation (or capnograph trace)

Fundus examination: only if suitably qualified and experienced paediatric ophthalmology expertise available.

** These tests can be done on either blood or urine*

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

INVESTIGATIONS AND TESTS UNDERTAKEN AFTER FAILED RESUSCITATION

(To be completed by the Duty Consultant Paediatrician)

	YES	NO
Blood culture		
Aerobic		
Anaerobic		
Blood Viral studies (5ml clotted blood)		
Urine sample (Suprapubic for infection, drugs, acy l-carnitine, MCAD),		
organic and amino acids		
Blood chemistry		
Neonatal screening **blood test card**		
Blood (5ml Lithium Heparin)		
Hb CO (Carboxy Haemoglobin)		
MetHb (Methaemoglobin)		
Liver function tests		
Amino acids*		
MCAD (Medium Chain Acyl-CoA-dehydrogense) *		
Blood drug assay (5ml clotted) *		
(Opiates, Benzodiazepines, Alcohol, Salicylates, Paracetamol)		
Blood (EDTA sample 2ml each) for		
Metabolic screen (Organic and Fatty acids) *		
DNA studies		
Swab visible blood before cleaning		
Photographs for autopsy (Discuss with Detective Inspector)		
Specific photograph		
Suspected NAI		
External anomaly		
Skeletal survey before postmortem:(discuss with radiologist)		
Independent check for ETT localisation		
* These tests can be done on either blood or urine		

Signature:
Name:
Date:

Appendix List

Appendix 1A - Immediate Decisions Pro-forma
Appendix 1B - SUDIC Contact Details
Appendix 1C - Child Death Notification

For details of Bereavement Support Organisations, refer to Appendix 2C

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

Appendix 1A-Immediate Decisions Proforma in Child deaths/ALTE

Child's Name	
Address	
NHS Number	

Actions to be completed with 1-2 hours of death being declared				
	Decision	*Circle as appropriate*	**Action**	*Action completed?*
1	Does death / ALTE meet criteria for a Joint Agency Response? (Death or collapse with no immediate apparent cause, or due to external causes, or in custody, or suspicious circumstances, or stillbirth with no healthcare professional in attendance)	**Yes / No**	If Yes, contact On-Call health professional, police, duty social worker and request they attend hospital	**Yes / NA**
2	Can a MCCD (Medical Certificate of Cause of Death) be issued?	**Yes / No**	If No, or if death meets other criteria for referral to coroner, contact the coroner's office	**Yes / NA**
3	Has a potential care or service delivery issue occurred?	**Yes / No**	If Yes, contact the Patient Safety Team	**Yes / NA**
3a	In relation to 3: Has a Datix form been completed?	**Yes / No / NA**		
3b	In relation to 3: Have obligations under the Duty of Candour been fulfilled? (Family informed, offered apology, invited to submit questions)	**Yes / No / NA**		
4	Are there any immediate actions necessary to ensure the health and safety of others, including family or community	**Yes / No / NA**	*If yes, describe here:*	

Child/Hospital Details			
Childs Name:		**Date of Birth**	
Hospital Number:		**Date of death and time:**	
Hospital Name:		**Place of death e.g., ED/Other (Specify)**	

5	***Describe the approach to supporting the family (key worker, end of life medical lead):***
Name of person completing form	
Job title	
Date	

Appendix 1B - SUDIC Contacts

CHILD DEATH NOTIFICATION to be sent via e-CDOP link
https://www.ecdop.co.uk/PANCheshire/Live/Public
to CDOP Administrator
cdop@mcht.nhs.uk
TELEPHONE NUMBER:
01270 826060

To report a death / seek advice, contact the Coroner's Office:

All Areas (Crewe, Chester, Macclesfield, Halton & Warrington

All contact with a coroner during office hours (0830-1630 Monday to Friday only) should be made to the main coroner's office on 01925 444216 in the first instance, and the call will be transferred by the admin team to the coroner on duty.
01925 444216 – direct in-hours number for duty coroner, for urgent matters only

Calls outside of office hours should be made to the on-call out of hours phone (07970 112980) and will be dealt with by the coroner on call.

Senior Coroner - Ms Jacqueline Devonish (Coroner Devonish)
Main office (during office hours 0830-1630 Monday to Friday only)
On-call/out of office hours: 07970 112980

Area Coroner - Mrs Victoria Davies
Main office (during office hours 0830-1630 Monday to Friday only)
On-call/out of office hours: 07970 112980

Coroner's Officer Manager - Detective Inspector Darren Reid
Direct line: 01606 365227
Mobile: 07929 769596
Police Team: 01606 363892

HMC Coroner's Team Manager - Laura Jukka
Direct line: 01925 442107
Email address: ljukka@warrington.gov.uk

Coroner's Officers (Monday-Friday 8am-4pm):
01606 363 892

Warrington & Halton
Designated Doctor for Child Deaths:
Dr Kate Hunter
Tel No: 01925 662215 (In hours)
Email: kate.hunter2@nhs.net
CDOP Specialist Nurse: Sarah Rhodes
Tel No: 01925 867877
Mobile: 07464 521207
Email:
alwch.warringtonsafeguardingteam@nhs.net

Cheshire East (Crewe and Macclesfield District)
Designated Doctor for Child Deaths:
Dr Arumugavelu Thirumurugan
Tel No: 01270 273016 (In hours)
Email: arumugavelu.thirumurugan@mcht.nhs.uk
CDOP Specialist Nurse: Janice Bleasdale
Mobile: 07741 010973 (In hours)
Email:
janice.bleasdale@cheshireandmerseyside.nhs.uk;

cheshire.eastsafeguardingadmin@cheshireandmerseyside.nhs.uk;

Designated Nurse safeguarding Children and CiC
Nicola.wycherley@cheshireandmerseyside.nhs.uk;

Cheshire West & Chester
Designated Doctor for Child Deaths:
Dr Rajiv Mittal
Tel No: 01244 362083 (In hours)
Email: rmittal@nhs.net

CDOP/Specialist Nurse: Janice Bleasdale
MOBILE NO: 07741 010973 (In hours)
E-MAIL:
Janice.bleasdale@cheshireandmerseyside.nhs.uk;

cheshire.westsafeguardingadmin@cheshireandmerseyside.nhs.uk

Designated Nurse safeguarding Children and CiC
Sue.pilkington@cheshireandmerseyside.nhs.uk;

Appendix 1C - Child Death Notification

All child deaths / cases of ALTE that are unexplained and/or suspicious, requiring resuscitation and intensive care must be notified to Pan Cheshire Child Death Overview Panel (CDOP). Child Deaths must be notified via eCDOP, that can be accessed using the following link, by frontline staff dealing with the child death.

https://www.ecdop.co.uk/PANCheshire/Live/Public

eCDOP is the electronic portal for child death notifications (previously completed on Form A). As a minimum, staff must in addition notify Child Health Computer, GP and Named Nurse for Safeguarding Children locally. This is to avoid any delays in key staff being notified by CDOP as CDOP is not staffed on certain days of the week.

Upon receipt of notification, CDOP must ensure the child death is communicated to all relevant personnel including child death lead contacts within each Cheshire area and the Child Health Information System Computer (CHC) staff at the earliest.

CDOP should then send an email request to all relevant professionals to complete the Reporting Form (previously known as Form B), electronically on eCDOP, that would inform the review of the child death by CDOP.

For deaths in children who are not normally resident in Cheshire, Pan Cheshire CDOP would notify the relevant CDOP where the child is normally resident.

For out of area deaths in children normally resident in Cheshire, the CDOP area where the child died should notify Pan Cheshire CDOP. The same applies to child deaths in the devolved nations, of a child normally resident in Cheshire. Overseas child deaths should be notified to the CDOP where the child is normally resident by the Foreign Commonwealth Office.

Cases of **ALTE** that are unexplained and/or suspicious, requiring resuscitation and intensive care should be notified to Pan Cheshire CDOP via email at cdop@mcht.nhs.uk

Cheshire East, Cheshire West & Chester, Halton & Warrington

Section 2 Contents

1. Introduction

1.1 **Sudden Unexpected Death of an Infant or Child (SUDIC)** refers to the death (or collapse leading to death) of an infant or child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-exiting medical cause of death is apparent. This would also include unexpected death of a child with disabilities and/or chronic medical conditions or suspected self-harm. Also follow SUDIC process for cases of **Acute Life-Threatening Events (ALTE)** if deemed appropriate, reasonable, and proportionate by the professionals involved. ALTE is defined as ***"Any sudden unexpected collapse of an infant/child requiring some form of active intervention/resuscitation and subsequent intensive care/high dependency unit admission and remains unexplained and suspicious and has poor prognosis if child survives"***. Even if the child has been successfully resuscitated and admitted to intensive care, if the child is likely to die in the subsequent days or weeks or likely to suffer significant harm even if the child survives, it is advisable to follow this guideline. Where there is uncertainty, the Designated Doctor for child deaths is to be consulted. If in doubt, follow the SUDIC process. If child safeguarding procedures have been triggerred in such cases of ALTE, it may be okay to defer the initial Joint Agency Review (JAR) meeting, unless the child has died.

1.2 If factors in the environment, history or examination raise concerns or suspicions around the circumstances surrounding the death, these SUDIC guidelines should be followed, including where non-accidental injury is suspected to have resulted in the death of a child.

1.3 This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child.

1.4 This guidance should be used for the sudden, unexpected death of a child under the age of 18 years irrespective of place of death:

a. At home or in the community.
b. In the hospital's Emergency Department or any hospital Ward e.g., ICU or adult ward (unless there is a clear medical explanation or a natural cause).
c. Out of area or deaths abroad.
d. Or in the case of a stillbirth or out of hospital delivery where no health professional was in attendance.

The guidance should also be used for cases of ALTE (Acute Life-Threatening event) where the child may have survived but is highly likely to suffer / has suffered significant harm.

1.5 The guidance details a multi-disciplinary approach that will ensure to achieve:

e. Sensitive care and support to all affected by the death.
f. Preservation of evidence at the place of death.
g. Full documentation of all interventions by paramedical and medical staff, including resuscitation prior to the certification of death.
h. The completion of a full medical history by medical staff.
i. A full review of all the medical records of the deceased.
j. A paediatric pathologist (and if necessary, a forensic pathologist) investigating the cause of death.
k. A multidisciplinary case discussion.

1.6 It is essential that every professional involved in a Sudden Unexpected Death in Infants and Children (SUDIC) case must be fully aware of the guidelines and should keep meticulous records.

1.7 The sudden and unexpected death of any person demands the most thorough investigation of the highest standard. A sudden and unexpected death of an infant or a child (SUDIC) is no exception.

1.8 Aims of the Response to Sudden Unexpected Death in Childhood

Aims of the response to SUDIC are to:

1.8.1 Establish as far as possible, the cause/causes of the death.

1.8.2 To provide sensitive care and support to all those affected by the death.

1.8.3 Identify any contributory or modifiable factors.

1.8.4 Provide ongoing support to the family and ensure they are kept fully informed

1.8.5 Ensure that all statutory obligations are met i.e., as outlined in Working Together 2023.

1.8.6 Identify lessons learnt to reduce future child deaths.

1.9 PRINCIPLES

When dealing with sudden unexpected child death (SUDIC), all agencies need to follow common principles as follows:

- A sensitive, caring, open-minded and balanced approach.
- An awareness of religious and cultural differences.
- An inter-agency response.
- Sharing of information.
- Appropriate response to the circumstances.
- Preservation of evidence.

Investigation of a SUDIC case is a multi-agency responsibility and all the professionals who are involved in the case are inter-dependent for sharing of information with the proficient level of expertise. It is strongly advised that this guidance should be read as a whole and not just the section related to the practitioner's own particular role.

1.10 DEFINITIONS

1.10.1 **SUDI** – Sudden Unexpected Death in Infancy – In this context, this term is used for infants up to 24 months of age to facilitate use with other agency investigations.

1.10.2 **SUDC** – Sudden Unexpected Death in Childhood – refers to sudden unexpected death in child above 24 months but less than 18 years of age.

1.10.3 **Expected and Explained**

Child expected to die and cause of death explained.

Example: A child with malignancy who dies in appropriate circumstances.

This guidance does not need to be followed in these circumstances.

Death in a hospice is generally expected and explained. However, if there have been concerns raised about the circumstances around the death, it should be discussed with the Coroner.

NB: Notification of child death via eCDOP to CDR partners must be completed. (See Appendix 2B)

1.10.4 **Expected and Unexplained**

Child expected to die, and the cause of death is not explained by the condition. Example: A child with malignancy who dies earlier than is expected or in unexplained circumstances. The responsible clinician (General Practitioner, Consultant Paediatrician or the Emergency Department Consultant) is advised to discuss the case with the Designated Doctor for Child Deaths / Coroner to decide as to whether a complete investigation is indicated as per the SUDIC guidelines.

NB: Notification of child death via eCDOP to CDR partners must be completed. (See Appendix 2B)

1.10.5 **Unexpected and Explained**

Unexpected death of a child and cause of death explained but not due to unnatural/external causes and no suspicious factors E.g., Meningococcal Sepsis.

In these circumstances if a satisfactory explanation is determined then the SUDIC procedure need not be followed. If in doubt, discuss with Designated Doctor for Child Deaths.

NB: Notification of child death via eCDOP to CDR partners must be completed. (See Appendix 2B)

1.10.6 **Unexpected and Unexplained**

Where no cause of death is identified at autopsy and no suspicious circumstances or features to suggest unnatural death or inflicted injury; Applicable to SUDI cases, where the circumstances do not fit criteria for SIDS (sudden infant death syndrome) E.g., deaths in which history, scene or circumstances suggest a high likelihood of asphyxia but in which positive evidence of accidental asphyxia is lacking.

Follow SUDIC Guidelines.

NB: Notification of child death via eCDOP to CDR partners must be completed. (See Appendix 2B)

1.10.7 **SIDS - Sudden Infant Death Syndrome**

Refers to sudden unexpected death of an infant under 12 months of age, with onset of lethal episode apparently occurring during normal sleep, which remains unexplained after a thorough investigation including performance of a complete post-mortem examination, review of circumstances of death and clinical history

Follow SUDIC Guidelines.

NB: Notification of child death via eCDOP to CDR partners must be completed. (See Appendix 2B)

It is recommended that:

- professionals working together in responding to unexpected child deaths use the terms “SUDI/SUDC” at the point of presentation to include all unexpected infant/child deaths.
- those deaths for which a clear medical or external cause is found should be referred to as such as soon as the cause is identified.
- those infant deaths under 12 months of age that meet criteria for a diagnosis of SIDS are labelled as such.
- All other unexplained deaths are referred to as “SUDI, unexplained”, “SUDC, unexplained” or “Unascertained” (legal term often used by coroners, pathologists and others involved in death investigation, where medical cause of death has not been determined to the appropriate legal standard, which is usually the balance of probabilities), until such time that the coroner issues a legal cause of death following an inquest, that has taken full account of the information from rapid response multiagency investigation and Final child death review meeting.

1.11 UNUSUAL CLINICAL SITUATIONS

There are situations that are not clear-cut and might need consultation with the designated paediatrician and others in the joint agency team, such as the following examples.

1.11.1 **The infant who is unwell at the time of presentation but who deteriorates rapidly and dies of possible septic shock and multi-organ failure due to presumed sepsis.** In this situation, the condition has arisen suddenly and unexpectedly, as most life-threatening cases of sepsis in infants do, but from the time that septic shock has become established, death can be anticipated despite the best efforts of paediatric intensive care unit (PICU) staff. If the attending paediatrician can certify the death as being due to sepsis, there is no requirement for a SUDI investigation. If there is insufficient evidence to certify death, the case must be discussed with the Coroner and the SUDI process initiated. This can be modified if the Coroner feels that no further investigation is required. In any event, a home visit would not normally be undertaken in such cases unless concerns were raised.

1.11.2 **In ALTE cases, the infant may be successfully resuscitated from an out-of-hospital arrest but die subsequently or may survive for a period of time.** The infant might live for days or weeks before dying, usually through withdrawal of care following discussions with the family. As the out-of-hospital arrest was sudden and unexpected, and the eventual prognosis is poor even if the child survives, the police may secure the scene but will not be able to do this indefinitely. Thus, such a presentation should be discussed with the Designated Paediatrician for Child Deaths. SUDIC procedure may need to be followed despite infant remaining alive, as important information might be found that can assist the treating team and police.

1.11.3 **The child with a life-limiting or life-threatening condition who dies suddenly and unexpectedly.** If a child with a recognised life-limiting or life-threatening condition dies suddenly or following a brief illness, a SUDI investigation might not be required. If there are concerns, the lead health professional should liaise with the Coroner. In any event, if the death was not expected, the lead health professional should have a discussion with other members of the joint agency

response team, and the clinical team who know the child and family and reach a decision on whether a SUDI investigation should be initiated. Again, if in doubt, the designated lead health professional should consult with the Coroner / Designated Doctor for Child Deaths.

1.11.4 **Twins and multiples.** Twins and multiples have around twice the risk of Sudden Infant Death Syndrome (SIDS) compared with singletons. Components of risk vary in different studies and include preterm gestation, low birth weight and zygosity. The immediate concern of a family that lost one twin to SIDS is losing the surviving twin also to SIDS. The concordance rate for losing both twins to SIDS is difficult to estimate, due to small numbers, but was around four times that for the overall risk of a twin in one study. Malloy and Freeman found that the relative risk of a second twin dying in their study was eightfold; in one of their seven cases, the co-twins died on the same day, while the other six deaths were separated by a mean of 14 weeks. When one twin dies from SIDS, the surviving twin should be admitted to an inpatient paediatric unit for close monitoring for at least 24 hours. Investigations to exclude infection, inherited metabolic disease or an underlying cardiac condition should be undertaken. Follow-up support should be organised prior to discharge. In most areas, this will be provided by enrolling the infant on to the 'Care of Next Infant' (CONI) programme, a longstanding national programme managed by The Lullaby Trust, usually delivered by health visitors, which coordinates additional support to bereaved parents. This would also apply to surviving triplets and other multiples.

1.11.5 When a newborn infant suddenly collapses and dies in a neonatal unit, consideration must be given as to whether a joint agency response is required. In most situations this may not be necessary.

1.11.6 Still births where a health professional was not in attendance would require SUDIC process to be followed.

1.12 CHILD DEATH OVERVIEW PANEL (CDOP)

Child Death Overview Panel (CDOP) has a statutory responsibility to review all infant/child deaths 0-18 years who reside in Cheshire, regardless of where the death took place; this includes perinatal and neonatal deaths were registered as a live birth. Review of deaths following a live birth secondary to a planned termination under the abortion Act 1967 will not be carried out.

1.13 Glossary of terms

AHP	Allied Health Professionals
ALTE	Acute Life-Threatening Event
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
Child	A *child* refers to those aged over 12 months and under 18 years of age.
Children's Safeguarding Partnership Arrangements	Previously Local Safeguarding Children Board (LSCB)
CAMHS	Child and Adolescent Mental Health Services
CDR	Child Death Review
CDRM	Child Death Review Meeting
Child Protection Plan	A multi-agency plan for children identified as being at most risk of significant harm in the community. A social worker is always the lead professional for these children.
CONI	Care of the Next Infant
CSC	Children's Social Care
CPS	Crown Prosecution Service
CPT	Child Protection Team
Crime Manager	The senior police officer within a Police division in charge of Crime Investigation Department (CID).
DI	Detective Inspector (Police)
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department, which is the preferred name of an accident and emergency department.
FLO	Police Family Liaison Officer
FME	Force Medical Examiner
Forensic Pathologist	Home Office Pathologist (see below)
Frenulum	A fold of membrane that limits the movement of an organ. In these circumstances it means the upper lip unless otherwise specified. It may also be applied to the tongue or foreskin of the penis.
Form 92	Police Report on Sudden Deaths
GP	General Practitioner
Home Office Pathologist	A pathologist with special training as a forensic Pathologist who is on the Home Office list of accredited forensic pathologists.
Infant	For the purposes of this document, the medical definition of 'infant' is a child of less than 12 months of age is used rather than the legal definition which
ICU	Intensive Care Unit
JAR	Joint Agency Response
LeDeR	Learning Disabilities Mortality Review
M&M	Mortality and Morbidity meeting
MCCD	Medical Certificate of Cause of Death
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MHA	Mental Health Act
NCISH	National Confidential Inquiry into Suicide and Homicide by people with mental illness
NCMD	National Child Mortality Database

NHS	National Health Service
NIV	Non-invasive ventilation
Ofsted	Office for Standards in Education, Children's Services and Skills
ONS	Office for National Statistics
PICU	Paediatric Intensive Care Unit
PMRT	Perinatal Mortality Review Tool
PPO	Prisons and Probation Ombudsman
Postmortem	This refers to the medical examination which happens after death. It is sometimes referred to as an 'autopsy'.
RCP	Royal College of Physicians
SIDS	Sudden Infant Death Syndrome
SIO	Senior Investigating Officer
SJR	Structured Judgement Review
SMART	Specific, Measurable, Attainable, Relevant, Time-bound
SUDI	Sudden Unexpected Death in Infancy
SUDC	Sudden Unexpected Death in Childhood
SUDI/C Guidelines	Sudden Unexpected Death in Infancy/Childhood: multi-agency Guidelines for care and investigation
SUICIDE	Suicide is the act of taking one's own life. It is a term ascribed to a mode of death only after conclusion of the Coronial investigations.
WTSC 2018	Working Together to Safeguard Children 2018

1.14 General considerations

Following a death of an infant or child:

- No matter how brief your time with the family, your attitude and actions will be remembered.
- Maintain a supportive attitude while retaining professionalism.
- Grief reactions will vary; individuals may be shocked, numb, withdrawn, or hysterical.
- The child must never be left unattended, and an appropriate professional should be discreetly present with the family as the child is handled, at all times.
- Handle the child with naturalness and respect, as if the infant/child were still alive.
- Always refer to the child by name.
- Deal sensitively with religious beliefs and cultural differences while remembering the importance of evidence preservation.
- Parents/carers should be asked whether there are any specific Religious or cultural matters which they would like to be observed.
- Carers and parents will need to be given time to ask questions.
- Give written information to the family.
- In most cases a postmortem will be performed.
- Practical matters will need to be addressed (where the infant/child will go, what will happen, when the parents will see their child).

2. Practice guidance for all agencies

2.1 All professionals attending a child death, whether in the community or in a hospital setting, must abide by the following principles.

2.1.1 If the family is not currently known to agencies, then the primary support to the family will be given by health workers and the Police. However, should these agencies believe that other services are required then appropriate actions should be taken.

2.1.2 If the child shows any signs of life or where it is deemed that resuscitation is indicated, this should be commenced, and the child should immediately be taken to the nearest Emergency Department.

2.1.3 Where the child is clearly deceased, the body should remain at the scene until the Detective Inspector authorises the removal of the body. It should be remembered that in most cases of infant death the cause of death is natural and there is little evidential benefit for delaying the removal of the body.

2.1.4 In all deaths that occur in the community, the presumption is that the child's body should always be brought to the Emergency Department, in accordance with Working Together 2018 and Standards for Children and Young People in emergency care settings 2012. The purpose is to ensure that the body is

examined by a Consultant Paediatrician. However, there are exceptions to this situation:

2.1.4.1 In older children (including adolescents), this may not be necessary or appropriate. The DI should instigate a discussion with the duty Consultant Paediatrician to decide on the most appropriate course of action, to agree if there is a need for a Paediatric examination. The transfer of a body to the Emergency Department would be more likely if the death was unexpected and unexplained.

2.1.4.2 If the DI makes a policy decision that in the interest of securing and preserving evidence at the scene, the body should remain in situ. The DI should consult with the duty Paediatrician as part of this decision-making process.

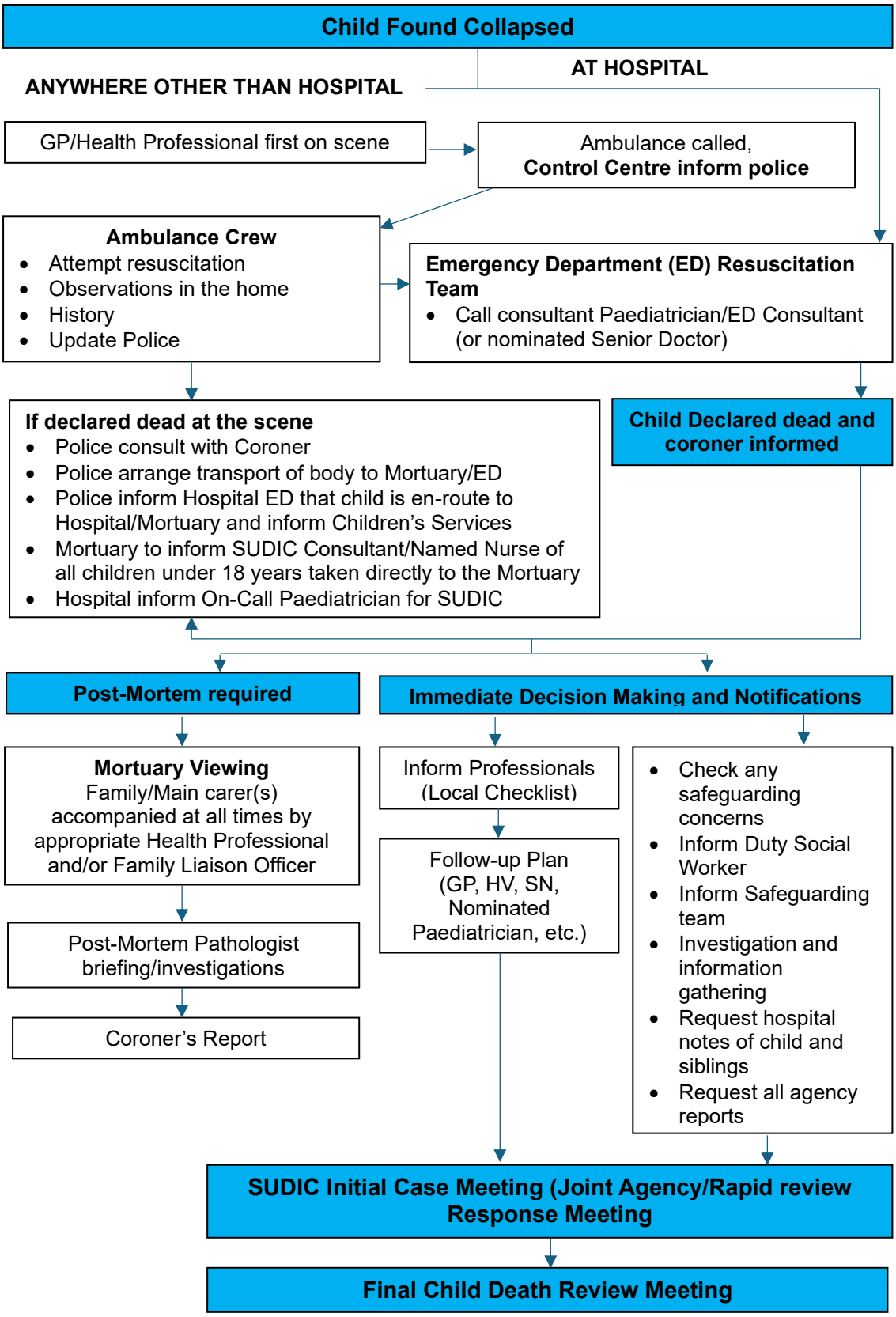
2.1.5 The presumption is that the child's body will be transported to the Emergency Department by North West Ambulance Service (NWAS).

2.1.6 The Coroner should be informed of the outcome of this discussion. Subsequently a SUDIC Initial Case Discussion meeting (Rapid Response Meeting) is held, at which all relevant agencies decide what should happen next and who will do what.

2.1.7 It is essential that parents' views about the postmortem are ascertained during the information-collecting session. However, no decision should be made or implied regarding the postmortem without discussion with the Coroner. The authority for holding or not holding a postmortem rest with the Coroner and the Coroner alone.

2.1.8 All individuals and agencies should ensure that their actions are legal, necessary, relevant, and proportionate in order to comply with the Children Act (1989 & 2004) and the Human Rights Act (1998).

2.2 Recommended Sequence of Events for SUDIC Process – Flowchart



2.3 Inter-agency working

2.3.1 The Duty Consultant Paediatrician and DI from the Police will inform the Coroner of any deaths of infants or children that meet the criteria for applying this procedure and ensure that a full multi-agency investigation will take place.

2.3.2 Every infant or child shall be taken to the Emergency Department ideally unless the DI after discussion with the Duty Consultant Paediatrician decides otherwise. The body will then be transferred to the mortuary before being transported to the hospital where the postmortem will take place (usually Alder Hey Children's Hospital, Liverpool, or Manchester Children's Hospital). The DI will liaise with the Coroner to decide whether a postmortem will take place and who will undertake it. The Police will arrange transportation of the body. However, in cases deemed suspicious, this process will be managed by the DI in order to preserve evidence. Parents/carers should be prevented from washing the child's body, as important forensic evidence could be lost by doing this. Where parents/carers want to stay with their baby, they should be supported in this, as long as there is a professional supporting them.

2.3.3 On arrival at Emergency Department, a lead health professional should be assigned, this maybe the on-call paediatrician or where arrangements exist, a designated paediatrician for SUDIC or specialist nurse.

2.3.4 Where no out-of-hours specialist provision for SUDIC exists, the on-call paediatrician should take the role of lead health professional but may transfer responsibility to a specialist professional the next working day; **however**, there must be a clear handover.

2.3.5 In circumstances where the death of a child has been confirmed outside of hospital, the child should still ideally be taken to the nearest ED with paediatric inpatient facilities, not the mortuary, in accordance with Working Together 2018 and Standards for Children and Young People in emergency care settings 2012. This allows for the earliest possible examination/assessment of the child by a senior clinician. Resuscitation should be attempted unless clearly inappropriate. The only exception to such children being taken to the mortuary rather than ED is where the police DI directs otherwise, in consultation with the SIO, on the grounds of preserving evidence in a suspicious death, or where there is a clear indication of cause of death.

2.3.6 The following documentation needs to accompany the body to the hospital where the postmortem will take place for the attention of the Paediatric Pathologist:

- Hospital case records.
- Ambulance notes.
- Emergency Department notes.
- SUDIC documentation form (Section 1) and relevant Notification form.
- Obstetric delivery notes of the mother if the child is less than three months old.
- Police Report on Sudden Deaths (Form 92).
- General Practitioner's notes.

2.3.7 The DI shall initiate the **immediate information sharing and planning** discussion with the Duty Consultant Paediatrician as soon as possible. This discussion usually takes place in the Emergency Department before the family leaves.

This should include consideration of outstanding investigations, notification of agencies, arrangements for the post-mortem examination, and plans for a visit

to the home or scene of collapse by those with appropriate forensic training. Following this visit, the lead health professional should prepare a report for the pathologist, Coroner and the police investigator. This report should also be forwarded to the relevant CDOP administrator.

2.3.8 A check with the Local Authority's Children's Social Care Service must always be made at this stage.

2.3.9 The purpose of the discussion is to:

- Share information to identify the cause of death and/or those factors that may have contributed to the death.
- Identify any at-risk factors and/or suspicious circumstances.

2.3.10 Joint Death Scene Visit

Following the unexpected death of an infant or child in a non-hospital setting, the DI will ensure a thorough assessment of the scene of collapse is undertaken, that will include photographs and/or video footage of the scene. The DI and health professional should review and consider all relevant material (including photographs/videos of the scene where available), to inform the option of conducting a home visit. This is particularly important for sudden unexpected child deaths under 2 years of age. (For guidance, please see Appendix 2D, Guide to the Assessment of the Environmental Circumstances of the Death).

It may also be appropriate for social worker to accompany if a joint home visit is deemed necessary. It is crucial for Police to ensure video footage and photos of the scene of death are made available at the SUDIC Case meeting (Rapid Response meeting), to inform discussions around the circumstances and cause of death, help progress relevant child death procedures and plan appropriate support for the family.

2.3.11 Immediate Decision Making and Notifications

This section relates to the immediate actions to be taken after the death of a child, such as notification of death, or deciding whether other investigations are warranted. In practice, the majority of such discussions will happen in a clinical setting but may require input from other agencies in certain cases.

2.3.12 A number of decisions need to be made by professionals in the hours immediately following the death of a child. These include:

- How best to support the family.
- Whether the death meets the criteria for a Joint Agency Response.
- Whether a Medical Certificate of Cause of Death (MCCD) can be issued, or whether a referral to the coroner is required and
- Whether the death meets the criteria for an NHS serious incident investigation.

A number of notifications should also be made to the child's GP and other professionals; to the Child Health Information System; and the relevant CDR partners and CDOP.

2.3.13 Investigation and Information Gathering

This section is predominantly for those involved in the preliminary stages of the child death review process in the aftermath of a child's death. It also summarises other investigations that may run in parallel to the CDR process.

After immediate decisions and notifications have been made, a number of investigations may then follow. These include:

- Coronial investigation.
- Joint Agency Response.
- NHS Serious Incident Investigation.

Post-mortem examinations may be required in a number of cases. Which investigations are necessary will vary depending on the circumstances of the individual case. They may run in parallel, and timeframes will vary greatly from case to case.

2.3.14 Joint Agency Response

A Joint Agency Response should be triggered if a child's death:

- Is or could be due to external causes.
- Is sudden and there is no immediately apparent cause (including SUDI/C).
- Occurs in custody, or where the child was detained under the Mental Health Act.
- Where the initial circumstances raise any suspicions that the death may not have been natural or
- In the case of a stillbirth where no healthcare professional was in attendance.

In any of these circumstances, the on-call health professional, police investigator, and duty social worker should be contacted immediately so as to initiate the joint agency response.

A Joint Agency Response should also be triggered if such children are brought to hospital following an unexpected collapse event, are successfully resuscitated, but death is anticipated to be highly likely in the following days. In such circumstances the Joint Agency Response should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur. Appropriate clinical investigations should also be performed in these cases. Details of the recommended samples to be taken and the purposes for which they are intended are included in the Documentation Section 1. Routine suggested samples to be taken immediately after sudden unexpected deaths in infancy and childhood.

Effective cross-agency working is key to the investigation of such deaths and to supporting the family, and requires all professionals to keep each other informed, to share relevant information between themselves, and to work collaboratively.

A lead health professional should be assigned. This person may be a doctor, senior nurse or health visitor with appropriate training and expertise. This person will ensure that all health responses are implemented and be responsible for on-going liaison with the police and other agencies.

2.3.15 Essential Components of Joint Agency Response

The essential components of joint agency response are:

- Careful multi-agency planning of the response.
- Ongoing consideration of the psychological and emotional needs of the family, including referral to bereavement services.
- Initial assessment and management, including case history, examination of the child, preliminary medical forensic investigations, and immediate care of family, including siblings.
- An assessment of the environment and circumstances of the death.
- Standardised Postmortem.

3. Factors that suggest a death may be suspicious

3.1 There are certain factors in the history or examination of the child which may give rise to concerns about the circumstances surrounding the death. If any such factors are identified it is important that the information is documented and shared with senior colleagues, the Coroner and relevant professionals in other key agencies involved in the investigation.

3.2 A list of such factors has been produced. The list is intended only as a guide and is not exhaustive.

3.2.1 **Previous child deaths.** However, there are some rare genetic disorders which can cause multiple cot deaths within a single family. In such cases an extended family history should be obtained, and the involvement of a clinical geneticist may be helpful.

3.2.2 **Previous child protection concerns** within the family relating to this child or to their siblings.

3.2.3 **A previous history of domestic abuse** within the family.

3.2.4 **Delay in seeking help** without adequate explanation.

3.2.5 **Inconsistent explanations.** The account given by the parents/carers of the circumstances of death should be documented verbatim. Any inconsistencies in the story given on different occasions should raise suspicions, although it is important to bear in mind that some inconsistencies may occur as a result of the shock and trauma caused by the death. Explanations as to how injuries occurred should be placed under detailed scrutiny when:

- The explanation changes with time or questioning.
- The ‘accident’ was beyond the child’s development (for example between two- and eight-months children are not usually walking and therefore do not fall unaided; they can, of course, fall from a height).

3.2.6 **Evidence of drug/alcohol abuse** particularly if the parents/carers are still intoxicated.

3.2.7 **Evidence of significant parental mental health problems** including fabricated/induced illness.

3.2.8 **Unexplained injury.** Any evidence of major bleeding or injury (cranial, bony, visceral or soft tissue) is highly suspicious unless proven otherwise. An examination of the child should seek to establish the presence or otherwise of unexplained bruising/burns/bite marks/ presence of blood, including:

- Multiple bruises to the face, ears, limbs, or trunk.
- Bruising to immobile children or bruising that is out of context with the child's development.
- Fingerprint bruises and linear bruises are highly suspicious.
- The frenulum – the narrow fold of mucous membrane preventing the lips from moving too far away from the gums - can be torn through such actions as force-feeding (but note that this could also happen during vigorous resuscitation).
- Petechial haemorrhages may or may not be present with suffocation and its absence is not conclusive either way, but their presence should be noted and discussed with the paediatrician, ophthalmologist, or pathologist (see glossary of terms).
- Blood around mouth and nose.
- A small amount of bleeding around the mouth and nose may be normal but a lot of blood should be treated with suspicion. Some froth around the mouth may be normal. However, in either case medical opinion should be sought.
- When on any other part of the body the injuries are burns, scalds, bite marks or injuries to the bone.

3.2.9 **A photographic record should** be made of all injuries immediately and again after 24 hours. This will be organised by the DI.

3.2.10 **Neglect issues.** Observations about the physical condition of the child and of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing and bedding, and temperature of the environment in which the child is found are important. This will assist in determining whether there may be any underlying neglect issues involved.

3.2.11 Shaking injuries

- These injuries present with non-specific symptoms ranging from apnoea, apparent life- threatening event (ALTE), seizures, unexplained drowsiness and/or 'sudden loss of consciousness' A high index of suspicion leads to identification of characteristic retinal haemorrhages on examination of fundi and subdural haemorrhages on CT scan. However, the diagnosis of shaking injuries from either CT scan or retinal injuries requires special expertise and utmost caution must be exercised prior to diagnosis.
- The photographs of the retina for signs of haemorrhage may prove invaluable.
- An experienced paediatric ophthalmologist may be able to differentiate between a shaking haemorrhage and one caused by brain swelling due to other causes.
- During resuscitation, a screening test for blood clotting disorders should be carried out promptly as brain injuries will eventually cause a similar effect. A photographic record should be made of all injuries immediately (and again after 24 hours).

3.2.12 Abusive Head Trauma

- These injuries present with non-specific symptoms, ranging from apnoea, apparent life- threatening event (ALTE), seizures, unexplained drowsiness or

'sudden loss of consciousness'. An appropriate suspicious mindset can result in the identification of characteristic retinal haemorrhages on examination of fundi and subdural haemorrhages on CT scan.

- Photographs of the retina for signs of haemorrhage may prove invaluable. An experienced paediatric ophthalmologist may be able to differentiate between a shaking haemorrhage and one caused by brain swelling due to other causes, but it is recognized the expertise may not be available in all secondary care hospitals, especially out-of-hours.

3.2.13 Previous convictions of parents and cares, in particular violence to children

- The police at the information-sharing briefing will be able to give this information.

3.2.14 If the infant had a learning or physical disability, or a significant pre-existing medical condition

- A further indicator could be a socially withdrawn infant.

3.2.15 Live Births resulting in neonatal death after a concealed pregnancy

- A concealed pregnancy is described as a women or girl who conceals the fact that she is pregnant or where a professional has a suspicion that a pregnancy is being concealed or denied, or women or girl significantly delays access to antenatal care.
- The SUDIC process should be followed for all such cases.

3.2.16 NHS Serious Incident Investigations

NHS serious incident investigations, when initiated, should inform the SUDIC Case Meeting process through providing a detailed analysis of patient safety incidents that may have contributed to the death by the way of a Reporting Form. Serious incident investigations should occur when it is thought that a higher level of investigation (using Root Cause Analysis (RCA) or any future methodology endorsed by the Healthcare Safety Investigation Branch (HSIB) might help clarify understanding of the event and support subsequent improvements in safety.

Consideration should be given to instigating the NHS serious incident process.

3.2.17 Consideration should also be given to referring to HSIB to help identify system wide learning. Link to new CDOP guidance:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf

3.2.18 At this juncture, it is important to identify a key worker (see section 5).

3.2.19 SUDIC Initial Case Discussion Meeting (Rapid Response / Joint Agency Response Meeting)

A SUDIC Initial Case Meeting s**hould take place within 72 hours where possible or no later than five working days after the child's death**, ideally with the results of the preliminary postmortem findings. This will be chaired by the Safeguarding DI and the administration of the meeting will be supported by

health. The administrator will ensure that the meeting is recorded in writing and the minutes are circulated to appropriate agencies within five working days of the meeting. (See Appendix 2G) The meeting should decide if the case needs to be referred to the Safeguarding Partnership as a Serious Child Safeguarding Incident. (See Appendix 2O)

3.2.20 **Videos and photographs** of the scene of death taken by the Police should be used to inform the proceedings of the SUDIC Case meeting.

3.2.21 **The purpose of the SUDIC** Initial Case Discussion Meeting (Joint Agency / Rapid Response Meeting) is to:

- Share information to identify the cause of death and/or those factors that may have contributed to the death, including information from any home visits.
- Plan future care of the family, including who will provide the family with information about support groups, bereavement, etc.
- Identify any lessons to be learned from this process.
- Gather further information for the inquest.
- Share information from each agency from previous knowledge of the family and records. In particular, any reference to the circumstances of the child's death; previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family; neglect, failure to thrive, parental substance abuse, mental illness, or domestic violence. Information is also required about family members and others involved with the child.
- Identify a key worker and decide what should happen next.
- Share information about any subsequent single/joint agency investigations planned.
- Enable consideration of any child protection risks to siblings/any other children living in the household and to consider the need for child protection procedures and any other action, for example health overview for other children in the family.
- Agree when a final child death review meeting will be held within the subsequent 6 to 12 months.

3.2.22 Who should attend the SUDIC Case Meeting (Joint Agency / Rapid Response Meeting)?

- Safeguarding Detective Inspector.
- Designated Doctor for Child Deaths.
- CDOP/SUDIC/Safeguarding Nurse.
- Senior management representative from Children's social care.
- Hospital or community healthcare staff involved with the child at the end of his/her life, and those known to the family prior to this event.
- Primary care clinicians.
- 0-19 services.
- Other professional peers from relevant hospital departments and community services.
- Patient safety team if a serious incident investigation has taken place.
- Coroner's officer, if the case has been referred to the coroner.
- Ambulance Service.
- Education/nursery and
- Other practitioners for example, professionals providing bereavement support, fire services, housing, and PICU transport team, Child, and Adolescents Mental Health Service (CAMHS) and representatives from voluntary organisations, etc.

If unable to attend the meeting, then information must be shared, ideally in written format.

3.2.23 Where possible, the DI will ensure the preliminary postmortem report is available for the SUDIC Case Meeting.

3.2.24 The administrator will also ensure that the meeting is minuted and the minutes are circulated to appropriate agencies within five working days of the meeting.

3.2.25 Final SUDIC Child Death Review Meeting

A final SUDIC Child Death Review Meeting should be held as soon as possible after the final postmortem results are available. This will normally take place within about 6 to 12 months after the child's death. The meeting is a follow up meeting subsequent to the SUDIC Initial Case Meeting and will be convened and chaired by a relevant health professional (see Working Together to Safeguard Children 2018). The recommendations from this discussion will be submitted to the local CDOP, via a completed Analysis form, with a copy to the Coroner.

The Child Death Review Analysis Form (previously "Form C") must be completed. See Appendix 2J.

The meeting should decide if the case needs to be referred to the Safeguarding Partnership as a Serious Child Safeguarding Incident. See Appendix 2O - Serious Child Safeguarding Incident Notification Process.

3.3 Meeting with the Parents

Following the final SUDIC Child Death Review Meeting, the relevant health professional must meet with the parents to discuss the postmortem results and any learning.

4. Role of the Police

4.1 The sudden and unexpected death of a child demands the most thorough investigation of the highest standard and meticulous records should be kept. In order to assist investigating and attending officers and staff in responding to the SUDIC, whether or not there are suspicious factors, regardless of how the death occurred, the Child Death Investigation Booklet has been created and is to be treated as the primary record during the investigation of the child's death. The booklet is held on the Constabulary intranet and is searchable using the term 'Child Death Investigation Booklet'. In cases where there is suspicion of a crime it is not to be used instead of the ACPO (2006) Murder Investigation Manual guidance on infant deaths, but as a supplement to it.

4.2 It is important to remember that in the vast majority of child deaths, the cause is natural.

4.3 There needs to be a careful balance between consideration for the bereaved family and the potential of a crime having been committed.

4.4 In any case of the sudden and unexpected death of an infant or child the police have a duty to investigate the death on behalf of the Coroner.

4.5 The Coroner must be notified as soon as possible.

4.6 The purpose of the police investigation is to determine the circumstances surrounding the death and to ascertain whether there is criminal involvement by any person. Such deaths will always be treated initially as suspicious and remain so until determined otherwise.

4.7 In relation to all sudden and unexpected infant or child deaths the On Call Public Protection Detective Inspector (DI) (Accredited at PIP 2) will be informed (through Cheshire Police Force Control Centre) and will retain overall responsibility for the investigation. The DI must adhere to the five national principles for dealing with SUDIC and be mindful of religious and cultural differences:

- Balance between sensitivity and investigation mindset.
- An awareness of religious and cultural differences.
- Multi-agency responsibility.
- Sharing information.
- Appropriate response to the circumstances.
- Preservation of evidence.

4.8 The DI will take command of the investigation. They should have completed the National Child Death Training. The DI should make an initial assessment and if considered necessary, escalate the investigation to the On Call Senior Investigating Officers (Accredited at PIP 3). All suspicious deaths should be referred to the on-call Senior Investigating Officer (SIO).

NB: The Professionalising Investigation Programme (PIP) provides a structured development programme to embed and maintain investigative skills for police officers and police staff. It aims to deliver the capability to conduct professional investigations at all levels within the Police Service and in other sectors of Law Enforcement.

PIP provides consistent registration, examination, training, work-place assessment, and accreditation to a national standard at each level.

- PIP 1 – priority and volume crime investigations.
- PIP 2 – serious and complex investigations.
- PIP 3 – major investigations.

4.9 Police involvement may be likely to increase parents' levels of distress. They will require an explanation of the reason for police involvement. Officers should inform the parents that the police act on behalf of the Coroner and have a duty to investigate the circumstances of the death. The police involvement occurs in every case of sudden and unexpected infant/child death, and it is hoped the investigation will help identify how the child has died. In most cases parents will welcome any assistance in obtaining an explanation for their child's death and will wish to assist this process.

4.10 There are certain factors in the history or examination of the child, which may give rise to concern about the circumstances surrounding the death (cf. Para 3.2.1 to 3.2.15). If any such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation.

4.11 Parents/carers may be asked to provide a sample of blood/urine in order to assist with the investigation into the circumstances surrounding the child's death - this should be in collaboration with health colleagues. The requesting of samples from the bereaved is emotive and needs careful consideration. Ultimately, making the request is a matter for the Police DI and that will be based on the circumstances of the death in a proportionate way, but should always be considered, with reasons for or not being taken clearly documented with a rationale. The Police will arrange for a Forensic Medical Examiner (FME) to collect the samples if required. The samples taken should be appropriately labelled and sent for forensic analysis if appropriate.

4.12 Allocation of an officer / crime scene investigator to attend a reported death of a child must be carefully considered by the supervisor who must ensure that the officer feels and is able to cope with such an incident (for example, it would be inappropriate where the officer has also suffered the loss of an infant/child). Any representations made by an officer must be considered.

4.13 As the majority of unexpected infant/child deaths are ultimately determined to be from natural causes, the actions and behaviour of officers must be balanced. Officers at all times must be sensitive in the use of personal radios and mobile phones.

4.14 Police attendance must be kept to the minimum required; several Police Officers arriving at the house could be very distressing. Wherever possible, officers in plain clothes should be utilized and/or the use of unmarked vehicles considered.

4.15 A Cheshire Constabulary Form 200092 – Police Report on Sudden Death (Form 92) must be completed as soon as possible.

4.16 The officer must make a visual check of the child and its surroundings, noting any obvious signs of injury and property on the body.

4.17 It must be established whether the body has been moved and the current position of the child must be recorded on the Police Report on Sudden Death (Form 92).

4.18 In cases of sudden unexpected infant/child death where the body has not been removed from the scene and joint visit with a health professional has not been undertaken, a Force Medical Examiner must attend and confirm death irrespective of whether life has been pronounced extinct by paramedics. It is important for the Force Medical Examiner to comply with the Pan Cheshire SUCIC procedures, as outlined in this document.

4.19 Officers should remember that in all cases where the child has not been removed from the scene, any removal should be direct to the local Emergency Department and the body must be accompanied by the police. In certain circumstances e.g., older children, other arrangements may be made. However, the matter must be discussed with HM Coroner before any action is taken.

4.20 In addition to any other information, the following information must be included on the Police Report on Sudden Death (Form 92):

- Basic Medical history of the child and family including any previous child death.
- Where the child was and the sleeping position, if covered, state what with.
- What the child was wearing
- When the infant/child was last fed, by whom and food content.
- If applicable, when the child's nappy was last changed, by whom and where is it now.
- Has the child been well up until time of death?
- Last seen alive by whom.
- If applicable, what caused the adult to look at/check the child.
- Temperature of the scene.
- Condition of accommodation.
- General hygiene and availability of food and drink.
- Parents: any alcohol /tobacco /medication – last taken/current state.
- Residents of the home, those present at the time of the child's death and recent visitors to the home.
- Carbon-monoxide levels in the accommodation

4.21 An early explanation from the parent/guardian/carer is essential; all comments must be recorded; any conflicting accounts will raise suspicion. However, it must be borne in

mind that any bereaved person may be in a state of shock and possibly confused. Repeated questioning of the parent/guardian/carer by different officers must be avoided at this stage. Accounts must be taken separately from the parents/carers if they were present. Where possible the police and a doctor should interview the parents/carers together to avoid duplication of questions.

4.22 It is entirely natural for a parent/carer to want to hold or touch the dead child, providing this is done with a professional present this should be encouraged, as it is unlikely that forensic evidence will be lost. If the death has been considered suspicious the DI, should be consulted before a parent/carer is allowed to hold the child. All contact must be discreetly supervised and recorded.

4.23 After death is confirmed, the Coroner has control of the body and in suspicious cases mementos must not be taken without prior consultation.

4.24 A professional from the hospital may refer a sudden and unexpected infant or child death following admittance via the Emergency Department or where the child has died on a hospital ward. In such cases, officers need to be aware that paramedics and health professionals will have examined and made attempts to resuscitate the infant or child. This involves a variety of medical equipment. Officers should also be aware that any medical equipment used as part of this process may still be attached to the infant's body, including 'drip' and 'other' injection equipment, but the tubes, etc., will be cut to a short length. These should be left 'in situ' until removed by a pathologist.

4.25 In all cases HM Coroner/Coroner's officer for the relevant area must be informed of the death as soon as possible.

4.26 The Death Scene: Where no suspicious circumstances arise as a result of initial investigations, no further action in respect of scene preservation will normally be required. This will be the decision of the DI, having consulted with the officers who attended the scene and/or health professionals.

4.27 The DI/SIO will decide what forensic recovery is required based on the presenting circumstances. In doing so, consideration should be given to the following:

- Calling a Crime Scene Investigator. This should be considered as essential if photographs or video recording of the scene(s) are considered necessary.
- The video and photographs should be made available for the SUDIC Case meeting and used to inform the discussions regarding the option for a joint home visit
- Retain bedding (but only if there are obvious signs of forensic value, such as blood,
- vomit or other residues).
- Recovering articles from the infant's/child's last meal, (including previously prepared food/drinks, used bottles, cups, and food/leftover food) and any relevant medication. Record how the food/drinks have been stored.
- Taking bin contents (internal and external including used nappies), home videos, personal diaries/mobile phones/digital storage devices where relevant – e.g. in cases of suspected suicide of older children as these devices may contain significant information about their state of mind at the time.
- Where items are removed from the house, it must be explained to the parents that this may help to find out why their infant/child has died.
- Clothing (including any nappy) must remain on the infant/child. Wherever possible, any removal should be undertaken/supervised by a police officer, where the clothes have already been removed e.g., during medical intervention then they should be recovered.

4.28 The ‘Personal Child Health Record’ (or ‘Red Book’) should also be secured. The ‘red book’ is a parent owned record of the infant’s development completed by health professionals.

4.29 The Midwife/Health Visitor/School Health Nurse will have the child health records, which are confidential. These reports should be secured, as per local procedures.

4.30 Child abuse specialist officers have specialist skills, knowledge, and experience within the field of inter-agency child protection.

4.31 In all cases of sudden unexpected infant or child death contact must be made with the local PPD Detective Inspector/Supervisor. PPD Officers provide cover seven days a week, 0800 – 22.00 hours. Outside of these hours are force wide detective resources that the Force Control Centre will contact.

4.32 At the initial request of the DI the child abuse DS will be responsible for liaising with other agencies, in particular Children’s Social Care and Health.

4.33 It will be the responsibility of the police child abuse specialists to assess and deal with the need for any necessary protection of siblings. In cases where immediate protection is necessary, officers must adhere to the force policy on emergency protection contained within the Child Abuse Investigation and Safeguarding Children procedure.

4.34 At the hospital, the DI will discuss with the medical and nursing staff and any other professionals involved in the case:

- The cause of the death and/or those factors that may have contributed to the death.
- Any at-risk factors and/or suspicious circumstances.
- Whether the death is expected/ unexpected/explained/unexplained; whether a SUDIC Case Meeting needs to be convened and whether a home visit needs to take place.

4.35 The attending Duty Consultant Paediatrician will fully brief and provide the DI with a summary of the child’s known/ available medical history, (including any relevant background information concerning the family and any concerns raised by any other agency). The DI is responsible for ensuring that the pathologist is provided with this summary.

4.36 The named Nurse/Deputy will facilitate the provision of a clear, high-resolution copy of the following documents which should accompany the body to the postmortem examination for the information of the pathologist:

- Hospital case records/summary of these.
- Ambulance notes.
- Emergency Department notes.
- SUDIC guidelines forms, duly completed (Section 1).
- Obstetric/delivery notes of the mother if the child is less than three months old/child’s records

4.37 The duty DI, in conjunction with the responsible Duty Consultant Paediatrician and the Designated Doctor for Child Deaths, should arrange a SUDIC Case Meeting (Rapid Response Meeting), which should take place within 72 hours or no later than 5 working days of the child’s death in accordance with paragraph 3.2.19.

4.38 If the hospital has undertaken any investigations before death, including x-rays, pre transfusion blood samples, scans, etc., the DI, the Pathologist and the Coroner must be informed, and the results forwarded to the Pathologist/Coroner.

4.39 Where it is necessary to obtain full hospital records this will normally be facilitated in conjunction with the relevant named nurse for child protection, as per local arrangements. The Designated Nurse for Safeguarding Children will also assist in the coordination of gathering further information from health professionals, for example, health visitors/GP/ Mental Health Worker, etc.

4.40 When the infant/child is taken to the mortuary the body must be accompanied by a police officer. Where the parents wish to accompany their infant/child to the mortuary this must normally be facilitated but again they must be accompanied by a police officer.

4.41 The Postmortem: In infant or child death cases, HM Coroner for Cheshire has introduced the following strategy for undertaking a post-mortem examination and the decision will be final.

4.42 In non-suspicious cases a paediatric pathologist, if possible and available, will be instructed to conduct the postmortem examination.

4.43 In non-suspicious cases involving older children and adolescents or road traffic collision victims, the Coroner may order a general pathologist to carry out the postmortem examination.

4.44 If the postmortem examination reveals suspicious circumstances, then it will be halted, and the post-mortem continued jointly with a Home Office Pathologist.

4.45 If from the outset there is substantial suspicion, the coroner will direct a joint post-mortem, to be conducted by a Home Office Pathologist, who will take the lead, together with a Paediatric Pathologist.

4.46 In suspicious cases the SIO will arrange for a police postmortem team to attend the postmortem, the team will include the SIO (or appointed representative), an exhibits officer, pathologist, and a crime scene examiner.

4.47 The DI/SIO should be provided with the interim findings as soon as possible after the postmortem examination is completed. The interim findings may well be ‘awaiting histology, virology, toxicology’, etc. As much information as possible should be shared at the SUDIC Case Meeting.

4.48 The results of the interim findings should be conveyed to the family by the most appropriate professional.

4.49 The DI will ensure that the Police Report on Sudden Deaths (Form 92) is completed and forwarded to the pathologist and the Coroner as soon as possible.

4.50 On the directions of the Coroner, the DI will be provided with the postmortem examination final report. A copy of the report would also be provided to the Designated Doctor for Child Deaths (who will liaise with the Duty Consultant Paediatrician) and the Public Protection Directorate – Operational Teams.

4.51 No other agency will be allowed access to the postmortem report without prior approval from the Coroner. Permission should always be sought by any agency if the content of the report could potentially affect the agency’s future actions.

4.52 A Child Death Review Meeting should be held as soon as the final postmortem results are available. The meeting will be convened and chaired by the DDCD (WTSC 2018) within 6 weeks of availability of the final autopsy report.

4.53 Returning Property: Items of property which have been seized should be returned as soon as possible after the Coroner's verdict or the conclusion of the investigation. Parents must be asked in person if they wish for them to be returned. Bedding/clothing, etc. should be, as far as possible, returned in their original state. The return of these items should be handled sensitively (for example, where a bottle containing feed or juice is taken, the bottle should be returned clean, rather than in its original state). Official labels or wrappings must be removed before return.

4.54 Welfare: Police involvement with bereaved and traumatised families is amongst the most difficult of any situations an officer is called upon to deal with. It requires extreme sensitivity and may have a significant emotional impact on anyone coming into contact with the family including investigators.

4.55 Child Death Investigations can be complex and requires support and supervision. The DI/SIO must provide appropriate levels of support for every officer involved in this type of investigation regardless of outcome.

5. Role of Key worker

4.56 The processes that follow the death of a child are complex, in particular when multiple investigations are required on co-ordination across investigations). Recognising this, all bereaved families should be given a single, named point of contact to whom they can turn for information on the child death review process, and who can signpost them to sources of support. Given shift patterns and annual leave, Trusts should ensure that the key worker is supported by a team who can step in to cover absences. Families should expect to be able to contact the key worker or a team member during normal working hours.

4.57 It is the responsibility of the organisation where the child was certified dead to identify a key worker for the family. The role could be taken by a range of practitioners. For example:

- In the cases of children with long term conditions, the family may already be well known to a member of a specialty multi-disciplinary team such as a clinical nurse specialist, and this individual may be well placed to continue in a key worker role after the child has died; or
- In the cases of children with acute conditions (e.g., sepsis) the child and family may not have been known to any health care practitioners before the child's admission to hospital, and a key worker might instead be a member of the bereavement support team.

4.58 In criminal and coronial cases, the police family liaison (where deployed) and coroner's officer respectively provide vital support to the parents in relation to all elements of those investigations. In such situations, the key worker might play a supporting role in ensuring that the wider needs of the family are being met.

4.59 Regardless of professional background this person should:

- Be a reliable and readily accessible point of contact for the family after the death.
- Help co-ordinate meetings between the family and professionals as required.
- Be able to provide information on the child death review process and the course of any investigations pertaining to the child.
- Liaise as required with the coroner's officer and police family liaison officer.

- Represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards; and
- Signpost to expert bereavement support if required.

4.60 The key worker should have the following competencies

- An empathic approach, and an ability and willingness to listen to, and be with, people in distress.
- Strong communication and interpersonal skills in challenging and distressing situations.
- Ability to maintain appropriate boundaries with families.
- Sufficient experience and confidence to effectively represent the family at professional meetings; and ability to quickly develop a thorough understanding of child death review, in order to support the family through the process and answer any questions they may have.
- If the key worker is not already familiar with the child death review process, they should contact the local child death overview panel (CDOP) manager or Child Death Review Nurse Specialist or local Designated Doctor for Child Death. Also see the leaflet When a child dies - A guide for parents and carers (lullabytrust.org.uk)

5.6.1 The key worker must be appropriately supported as follows:

5.6.2 **Time.** How much time will be needed for the role may vary greatly from case to case. It is important that all NHS organisations are flexible in enabling the key worker to support each individual family as required, over the weeks and months following the death of a child.

5.6.3 **Team support.** Families should expect to be able to contact the key worker or a team member during normal working hours. Given shift patterns and annual leave, Trusts should ensure that the key worker is part of a supportive team who can step in to cover absences.

5.6.4 **Individual support.** Working with bereavement can be stressful. The key worker and their line manager should agree a plan to ensure that they are appropriately supported in the role, including opportunities for debriefing and supervision.

6. Role of Medical lead

6.1 An appropriate consultant neonatologist or paediatrician should also be identified after every child's death to support the family. This is distinct from the key worker, and might either be the doctor that the family had most involvement with while the child was alive or the paediatrician on-duty at the time of death. This individual should liaise closely with the family's key worker and arrange:

- Follow-up meetings at locations and times convenient to the family; and
- Clinical expertise (via other professionals if necessary) to be able to
  i) answer questions relating to medical, nursing or midwifery care of child.
  ii) explain the findings, investigation report where relevant including the post-mortem report, if approved by the Coroner, making it clear to parents that conclusions of the postmortem report may not be final cause of death and would only be determined at the conclusion of the Coroner's Inquest
  iii) report back the outcome from the CDRM
  iv) Consultant Paediatrician/Neonatologist (if coroner not involved) may need to refer family to Genetics team for counselling and Whole Genome Sequence (R441) testing, in cases where no cause of death identified on post mortem exam, after

establishing DNA sample is available for the child with Genetics and debriefing parents and Designated Doctor for Child Deaths. Referrals to be e-mailed to iccteam@lhch.nhs.uk, for the attention of Jessica Cadwallader (jessica.cadwallader1@nhs.net) - Genetics Counsellor and Inherited Cardiac Conditions Co-ordinator and Dr. Katya Bennett (katya.bennett@nhs.net) - Consultant Geneticist.

7. Guidelines for Ambulance Services

7.1 When the ambulance service is called to the scene of a sudden unexpected and unexplained death of a child, the attending crew must notify the ambulance control room. The duty control room manager **must notify** the police control room. The ambulance emergency control centre has responsibility to notify the police force of all cases of suspected or confirmed SUDIC and/or where there is reasonable cause for safeguarding concerns while processing a 999 call.

7.2 The recording of the initial call to the ambulance services must be retained for evidence purposes.

7.3 Ambulance staff should not assume that death has occurred. If the child shows any signs of life or where it is deemed that resuscitation is indicated, this should be commenced, and the child must immediately be taken to the nearest Emergency Department.

7.4 The first ambulance staff at the scene should:

- Obtain a history surrounding the death.
- Note the position of the child and the clothing.

7.5 If in doubt about death commence life support according to the guidelines.

7.6 Ambulance staff must inform the receiving Emergency Department of the child's condition and the expected time of arrival.

7.7 In all cases the child's body should be then brought to the Emergency department.

7.8 If the child is dead at the scene and further active resuscitation is not considered appropriate, then the body should remain in-situ, pending the arrival of the police. The body should then normally be taken by an ambulance to the local Emergency Department unless the DI, in consultation with the Coroner, directs otherwise.

7.9 In cases where death has occurred and the circumstances are suspicious, the body should only be removed with agreement of the SIO and the Coroner.

7.10 Anything suspicious must be reported directly to both the police and the receiving Doctor at the hospital.

7.11 Ambulance staff must pass on all the information including history, observations of the scene and resuscitation to the receiving physician.

7.12 Any other information gathered (e.g., background history, living accommodation, comments by those at the scene) must be passed on to the Emergency Department receiving doctor and the police.

7.13 It should be remembered that in most cases of infant deaths the cause of death is natural and there is little evidential benefit for delaying the removal of the body from the scene.

8. Guidelines for General Practitioners

8.1 The General Practitioner (GP) may be called to the scene first. In such cases they should adhere to the same guidelines as for the ambulance staff.

8.2 As soon as possible and within 24 hours, make a precise and thorough record of the event in the infant or child's record, making particular reference to:

- Any inappropriate delay in seeking help.
- The position of the infant/child and the condition in which it was found.
- Inconsistent explanations – accounts should be recorded verbatim in quotes.
- Evidence of drugs/alcohol abuse.
- Parents' reaction/demeanor.
- Unexplained injury e.g., bruises, burns, bites, presence of blood.
- Neglect issues.
- Position of the infant/child and surroundings.
- General condition of the accommodation.
- Evidence of high-risk behaviour e.g., domestic violence.

8.3 These guidelines refer to unexplained unexpected deaths. Where the cause of death is explained (as drowning, road traffic accident, suspected suicide, or burns), the GP should discuss with the Coroner to formulate the next course of action.

8.4 If there are no signs of life the GP will confirm death and inform the police (this is done by Police Control). The Police will inform the Coroner. The GP will inform the Responsible Paediatrician at the hospital to which the child will be taken.

8.5 The GP will be required to provide information to the Coroner/pathologist of the care provided by any hospital as soon as possible.

8.6 The GP will be expected to attend and/or provide information for the SUDIC Case Meeting (including Initial and Final Multi-Disciplinary Meetings) or at the earliest opportunity if they are not able to attend. In conjunction with the midwife and other health professionals, the GP will be involved in providing ongoing advice and support for the family.

9. Guidelines for Community Health Professionals – e.g., Health Visitor, School Nurse, and Community Nurse

9.1 The gathering of relevant information from the health visitor, community practitioners, school nurse and community nurse when a sudden unexpected child death occurs is required to aid the investigative process by the coroner.

9.2 In passing this essential information, the need to support the professional involved with the family prior to the death of the child must be recognised.

9.3 The DI or the Coroner's officer will contact the Named Nurse for Safeguarding Children and/or the CDOP Nurse (or equivalent) with the information of the child's name, date of birth, address, GP and the time of death.

9.4 The Named Nurse for Safeguarding Children and/ or the CDOP Nurse (or equivalent) will contact the health visitor, school nurse and or the community nurse to ascertain whether there have been any professional concerns regarding the health and parenting of the child.

9.5 The Named Nurse for Safeguarding Children and/or the CDOP Nurse (or the equivalent) and the Child Safeguarding Team (NHS) will pass the information to the Police/Coroner.

9.6 In the event of a health professional raising concerns and a police statement being required from the member of staff, a member of the Child Safeguarding Team (NHS) would be present to provide appropriate support.

9.7 The Named Nurse for Safeguarding children and/or the CDOP Nurse (or equivalent) will ensure that all known agencies working with the child have been informed of the child's death e.g., paediatric Allied Health Professionals, acute hospital paediatrician (SUDIC), audiology, midwifery services, community paediatricians, school nurse, Child Health Department, CONI coordinator (or equivalent), children's centers, etc., so as to avoid appointments being sent in the future.

9.8 The appropriate community health professional will ensure that parents have been given appropriate information about support groups and bereavement counselling services continue to offer support to the parents after the funeral, identify any medical or social needs and arrange appropriate support.

9.9 In case of an infant death, the parents shall be offered support with subsequent babies via the Lullaby Trust scheme and local Care of the Next Infant (CONI) arrangements.

10. Guidelines for Midwives

10.1 These guidelines inform midwives of the procedures in the event of a sudden unexpected death of an infant or child. Midwives should also refer to their own professional organisation's procedures/guidelines.

10.2 Records will be secured by the head of midwifery/their nominated deputy as soon as the death has been notified. A copy will be made available for the midwives. This is a precautionary measure until the situation is clarified.

10.3 **If the community midwife is first on the scene**, the midwife should not assume that death has occurred. If the child shows any signs of life or where it is deemed that resuscitation is indicated, this should be commenced, and the child should immediately be taken to the nearest Emergency Department via ambulance.

10.4 When an unexpected fresh stillbirth or sudden unexpected death has occurred without the presence of a health professional, or if the birth has been concealed, the midwife must assess the baby and the mother's medical condition and immediately call the paramedic services who will inform the police. The midwife should not complete the medical certificate of stillbirth and the GP should be informed.

10.5 Where the midwife has arrived after the birth and there is evidence of maceration or gross abnormality, she may complete the medical certificate of stillbirth if confident that the baby cannot have shown signs of life. In this event the Coroner's office will not need to be informed (NLSAGSM 2005).

10.6 Where the midwife has arrived after the birth and the baby appears normal and the midwife cannot confirm that the baby never showed signs of life, the local police should be contacted, who will then inform the Coroner. In such circumstances the Medical Certificate of Stillbirth should not be completed by the midwife and the GP should be informed.

10.7 If the indications are that the baby is dead and no active resuscitation has been attempted, the body and placenta should remain on the scene pending the arrival of the police. Try not to disturb the scene, i.e., do not touch or move anything.

10.8 The position of the baby and the condition in which it was found must be noted together with any comments/explanations of the mother or any other person at the scene.

10.9 When the paramedics arrive, spend time listening to the parents and offer support.

10.10 If the parent/carer goes to the hospital with the baby, ensure that appropriate arrangements are made for the care of any siblings.

10.11 If the mother is alone, ensure that she has the appropriate family support.

10.12 Give the parents/family a work telephone number where the Midwife can be contacted.

10.13 If the mother's condition requires obstetric intervention, she should be transferred with a midwife to the nearest maternity unit, whether she is booked there or not.

10.14 If the baby is not resuscitated the body will be taken to a hospital Emergency department.

10.15 If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the Police and Emergency Department staff as soon as possible.

10.16 As soon as possible and within 24 hours, make a precise and thorough record of the event in the infant /child's record, making particular reference to:

- Any inappropriate delay in seeking help.
- The position of the infant/child and the condition in which it was found.
- Inconsistent explanations – accounts should be recorded verbatim in quotes.
- Evidence of drugs/alcohol abuse.
- Parent/s' reaction/demeanor.
- Unexplained injury e.g., bruises, burns, bites, presence of blood.
- Neglect issues.
- Position of the infant/child and surroundings.
- General condition of the accommodation.
- Evidence of high-risk behaviour e.g., domestic violence.

10.17 The family GP and Child Death Review Nurse Specialist (or equivalent) must be informed as soon as possible.

10.18 In the case of a death on the maternity unit, also contact supervisor of midwives, co-coordinator on delivery suite and head of midwifery.

10.19 **If you learn later that a baby has died:** Check that the Child Death Review Nurse Specialist (or equivalent) is informed of the infant's death and has informed the Child Health Department and the list of agencies and professionals in Paragraph 9.7 above.

10.20 Discuss the support required for the parents/carers/extended family.

10.21 If the mother was breast feeding, discuss and advise on the suppression of lactation and give appropriate support. Refer to the GP if necessary.

10.22 Ensure that the midwifery records are available to the SUDIC Paediatrician and be available to attend any subsequent multi-agency meeting. If still visiting the mother, obtain and photocopy the handheld records and take the originals to the meeting.

10.23 Be prepared to provide a Statement of Evidence if requested and seek advice from the Designated Nurse/Named Midwife.

10.24 **The next pregnancy:** Ensure that all relevant professionals are informed, including the CONI coordinator, or equivalent, as soon as possible.

10.25 **Scrutinise previous records** to ascertain whether it is necessary to inform any other professional/agency of the pregnancy e.g., Social Worker. It may be necessary to liaise with the GP to obtain historical information.

10.26 Ensure that any previous infant death is highlighted in the maternity records.

10.27 Ensure that the family receives appropriate support during the pregnancy, delivery, and post-natal period.

11. Guidelines for Acute Hospital Staff

11.1 As soon as the emergency department is notified that the ambulance crew is attending the scene of a possible child death, the emergency department nurse in charge must notify the following:

- The on-call paediatric/resuscitation team.
- The on-call consultant paediatrician.
- The on-call emergency department consultant.

11.2 If there is any doubt about the duration of the collapse, full resuscitation must be commenced.

11.3 Ascertain the identity of ALL the people present and their relationship to the child, including those who have the parental responsibility.

11.4 As soon as the Emergency Department receives the notification of an arrival **a senior nurse should be assigned** to keep a record of the resuscitation process. This nurse should keep a log of all investigations undertaken during and after the resuscitation.

11.5 Another Emergency Department nurse should be assigned to act as the Liaison Nurse who will receive and support the parents.

Responsibilities of the Emergency Department Liaison Nurse:

- Organising the communication process with the parents and will be present throughout the process of information gathering and sharing.
- Arranging parental contact with the senior paediatrician after the resuscitation has been discontinued.
- Arranging and supporting the parents during their contact with the deceased child.
- Ensuring that the appropriate documentation and notification processes are completed.
- The Snowdrop Team at the Aldercentre provide a 24hr, 365 days a year response to families whose child dies at Alderhey or is taken to Alderhey following death for post-mortem exam. However, if parents prefer to use “2Wish” Bereavement Support Charity, verbal consent needs to be obtained from parents (see referral form in appendices)
- Working closely with the Consultant Paediatrician, Emergency Department Consultant and the police to ensure that all the evidence is preserved.
- Parent/carers could be offered a photograph of their child. However, any requests for mementoes, e.g., a lock of hair and hand/footprints, if agreed by the parents,

should be directed to the Coroner by the Paediatrician/ Nurse/Police. If mementoes are taken after postmortem by the Pathologist, the Police Coroner's Officer will then ensure safe delivery of the mementoes to the parents/carers. For those children taken to Alderhey for PM, locks of hair and hand/foot prints and memory boxes are taken by the families appointed KEY worker from the Snowdrop team at the Alder Centre after postmortem exam. Tel: 0151 252 5391; E.mail: www.alder.centre@alderhey.nhs.net

11.6 To identify the possible cause of death a detailed history should be obtained by medical staff (using the SUDIC History Record Forms).

11.7 History should include detailed family history including history of sudden unexplained deaths.

11.8 The comments of carer/parents must be recorded at all stages by a health professional in detail in case of future discrepancies or if suspicious circumstances develop.

11.9 Examination should start as resuscitation commences:

- The SUDIC document should be completed.
- Sites of medical lines must be marked: the site and route of any intervention,
- e.g., venipuncture, failed cannulation, intra-osseous needle, should be documented on the body chart.
- An endotracheal tube may be removed altogether (if the death is not suspicious) **but only** if a consultant, independent of any resuscitation attempt, establishes the correct positioning of the tube and documents the same in the notes. If the endotracheal tube is found to have been positioned incorrectly, the fact must be noted, and the tube left in place.
- A full general examination should be undertaken by the Consultant Paediatrician/Emergency Department Consultant noting any rashes, injuries on the child, state of any clothing or bed linen.

11.10 Hospital staff must retain all items of clothes/bedding for subsequent examination by the police or Coroner. They must not be returned without prior consultation with the Coroner.

11.11 Samples taken before death: blood, urine, CSF specimens and any other relevant specimens can be taken for appropriate investigations including microbiology, virology, toxicology and metabolic work-up as considered appropriate.

11.12 After death discuss with the Coroner before undertaking any investigations. It is recommended for various pathology samples and investigations to be undertaken as early as possible in hospital, especially specimens for culture and metabolic tests. A EDTA blood sample may also be obtained for DNA extraction and storage for Whole Genome Sequence studies if relevant, in cases where post mortem exam does not identify cause of death. The above tests are particularly important if there is likely to be a delay in post mortem exam.

11.13 The pro-forma must accurately record which tests have been obtained.

11.14 The attending Duty Consultant Paediatrician must ensure that all results of pre- mortem tests are forwarded to the Coroner and the pathologist.

11.15 If the child is **dead on arrival** or death is certified following arrival at hospital or when death is certified, the attending doctor should speak directly to the Coroner (or Coroner's officer).

11.16 A senior nurse should check that the police have been notified.

11.17 A skeletal survey would be carried out at the postmortem. However, if there are circumstances where an immediate x-ray examination is likely to add further information to the evidence, this should be discussed with the Coroner and the radiologist.

11.18 Notes of previous hospital, obstetric, emergency department attendances must be obtained.

11.19 Ascertain whether the child, or any sibling, is subject to a Child Protection Plan, or known to the local authority's children's services for any other reason. The Duty Consultant Paediatrician should review all hospital records of the child and siblings and prepare the report (within 48 hours) for any subsequent discussion/meetings. A copy of this report should be sent to the Coroner, Designated Doctor for Child Deaths (DDCD) and the pathologist.

11.20 Other professionals also need to be informed. This should be done by the Emergency Department Liaison Nurse in consultation with the NHS Trust checklist and the Appendices to this SUDIC Guidelines.

11.21 The parents/carers will need time to accept the information. Staff should be prepared for a range of reactions from the bereaved individuals.

11.22 An explanation should be given as to why the Coroner must be informed and that a postmortem will probably be necessary to try to ascertain the cause of death. It must also be explained that a paediatric postmortem will always involve the taking of tissue samples for histological examination.

11.23 A record should be made for every stage of contact with the family. This should include which health professionals were present for each contact. Careful documentation is required to include the full history, the verbatim comments and demeanor of the parents/carers.

11.24 Unless the circumstances of death are suspicious the parents/carers/family members should be encouraged to see and hold the child whilst discreetly accompanied by a professional. If the circumstances are suspicious, police advice should be taken.

11.25 Parents may accompany a child to the mortuary, if requested by them, cf. 11.24; A member of staff should always accompany the child to the mortuary. <u>The child should not be left unattended until arrival in the mortuary.</u>

11.26 Following the Rapid Response Meeting (Initial Multi-Disciplinary Meeting), the Consultant Paediatrician will liaise with the General Practitioner to decide on appropriate follow- up for the family.

11.27 The staff completing the SUDIC pro forma should ensure that the Emergency Department Liaison Nurse has arranged notification of child death form to the concerned agencies via e-CDOP.

11.28 Unexpected and Unexplained Death of a Child within a hospital setting:

11.28.1 When a child is found collapsed, the resuscitation team will be called, and full resuscitation shall be carried out.

11.28.2 When death is pronounced, the family will be informed and supported by a senior member of the staff.

11.28.3 If there are suspicious circumstances, the senior nurse on duty will inform the police.

11.28.4 The location of where the child collapsed should be treated as a scene of SUDIC investigation and preserved accordingly.

11.28.5 Follow SUDIC guidelines if any suspicious circumstances.

11.28.6 All information will be recorded as documented above.

11.28.7 Staff should be offered support and debriefing as appropriate.

11.29 **Where the death of a child occurs unexpectedly in hospital,** the Duty Consultant Paediatrician will discuss with parents and the Coroner to decide if there is an explanation for the child's unexpected death for issue of the death certificate. For example: an extremely pre-term neonate who was previously stable, a child with cerebal palsy with reflux and gastrostomy who develops a pulmonary aspiration with a fatal ALTE: there is little benefit in undertaking a postmortem. The Duty Consultant Paediatrician may sign the death certificate.

11.29.1 However, if the parents or staff have any concerns about the child's management from a medical or nursing perspective, then the case needs a thorough investigation. The Police will be involved if it is considered that there were suspicious circumstances around the child's death.

12. Guidelines for Children's Social Care Services

12.1 In the first instance Emergency Department staff will check with the Local Authority Children's Social Care Services whether the infant/child or any child within the same family is or has been known to them and if so, in what capacity.

12.2 Children's Social Care Services staff will check whether the child is subject to a Child Protection Plan, or an open referral (i.e., child in need) and check any other background records, which indicate any previous concern as to the wellbeing of the child or any other children in the family. Such information will be shared with the emergency department. At this stage, this information must be regarded as shared in confidence. Children's Social Care will decide if it is necessary for a practitioner to attend or carry out an assessment.

12.3 If the death appears suspicious and/or there are any concerns that a child has suffered, or another infant/child may suffer harm as a result of abuse then this should be referred directly to the Local Authority Children's Social Care Services following formal Safeguarding Children Partnership Arrangements procedures. Children's Social Care services will undertake appropriate assessments, including multi-agency Section 47 enquiries, as necessary.

12.4 If there are concerns about safeguarding responses by any agency, then the named doctor/named nurse for safeguarding should be consulted.

13. The Role of the Coroner and Pathologist

13.1 Upon receipt of a referral of death where a body is lying in the coroner area, HM Coroner has control of the body and will determine whether to conduct a Paediatric post mortem. HM Coroner will select a pathologist to undertake the post mortem and direct them as to the type of post mortem required, and may authorise the taking of samples. Samples cannot be taken without the express consent of HM Coroner.

13.2 In most cases of SUDIC, the postmortem will be performed by a paediatric pathologist. In older children and adolescents with road traffic accidents, the postmortem may be carried out by a general pathologist. If there are suspicious circumstances, HMS Coroner will direct a Home Office Pathologist to take the lead role in the post-mortem. If the paediatric pathologist does not agree the contents of a report proposed by the Home Office Pathologist, then each of them will issue a separate report. It is the Coroner who decides which pathologist will conduct the postmortem. The Coroner's office should ensure that the preliminary postmortem is shared as soon as possible with the police and the Designated Doctor for child deaths, and the final postmortem report with the Designated Doctor for child deaths as soon as possible via the relevant CDOP.

13.3 If there are suspicious circumstances HM Coroner is likely to authorise a Home Office Post Mortem alongside the Coroner's direction for a Paediatric post mortem. The type of post mortem is entirely a matter for the Coroner to decide.

13.4 HM Coroner must receive all relevant medical and clinical history upon request to enable full instructions to be provided to the authorised pathologist in a timely manner. The attending Duty Consultant Paediatrician must ensure that all results of pre- mortem samples are forwarded to the Coroner and the pathologist. The DI or the Coroner's Officer also must ensure that results of all investigations initiated during the postmortem (i.e. toxicology, other tests undertaken by forensic scientists) are forwarded to the pathologist(s) as soon as they became available (which will facilitate the timely conclusion of the final post mortem report). It is the responsibility of HM Coroner's officer to ensure this has taken place.

13.5 The Coroner's officer must ensure that all relevant professionals who have notified the Coroner that they wish to attend the postmortem, are informed of the time and place of the postmortem. Coroner's Office must inform parents at their initial contact, that a sample of tissue would be sent by the Pathologist to Genomics lab for DNA extraction and storage (not for testing at this point), and that genetic studies may be undertaken on the sample if no cause of death identified on post mortem exam, provided criteria for genetic testing is met. In such cases, following a referral by the Coroner, the Genetics team will get in touch directly with parent(s) to discuss further and obtain Informed Consent at around 6 to 8 weeks from referral.

13.6 The post mortem report is the property of HM Coroner and the pathologist must report directly to HM Coroner with the findings. The post mortem report cannot be shared without the prior approval of HM Coroner. HM Coroner is an independent Judge and all decisions made are judicial decisions which must be complied with. HM Coroner does make requests, but issues Court Orders in accordance with statutory powers. To enable HM Coroner to comply with the statutory obligation to complete investigations within six months, the post mortem report must be produced within the timeframe directed by HM Coroner. HM Coroner's consent must be obtained if the family wish to view the body ahead of a post mortem. HM Coroner will have direct communication with the police where criminal investigations are underway. The police will also communicate with the Consultant Paediatrician for child, Designated Doctor for Child Deaths and Pathologist.

13.7 The postmortem examination shall be carried out promptly. All persons involved with these guidelines will cooperate to this end. A full post-mortem report shall be provided in writing to the Coroner as soon as possible. A full post-mortem report shall be provided in writing to HM Coroner within 28 days. All investigations are to be concluded within the shortest possible time, to enable:

- The prompt funeral of the child.
- The expeditious conclusion of the inquest into the death of the child.

13.8 In the event of a suspicious death the SIO (or appointed representative) and the crime scene officer must attend the postmortem.

13.9 A paediatric post-mortem will always involve the taking of tissue samples for histological examination and the Paediatric or Emergency Department Consultant or most senior doctor present will explain this to the family. It is the responsibility of HM Coroner's officer to ensure that instructions are taken with regard to tissue samples. The Pathologist should ensure a sample of splenic tissue is always stored for Whole Genome Sequence testing, on Coroner's request, should the criteria be met.

13.10 If the Pathologist carrying out the post-mortem examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) (s)he will ask the permission of the Coroner first. The Coroner, through his officer, will enquire of the family as to their wishes for the ultimate disposal of the organ so retained.

13.11 Pending on the circumstances of death and the post-mortem findings the pathologist may require highly specialised investigation of various organs (mainly brain and/or eyes in cases of suspicious non-accidental injuries) which would involve (paediatric) neuropathologist and/or ophthalmic pathologist and/or pathologist of the skeletal system (bones).

13.12 All samples taken at postmortem are under the control of the Coroner and must be labelled, identified and dealt with in accordance with the guidelines.

13.13 The interim results of any postmortem will be communicated immediately to the Coroner by telephone. Bearing in mind possible legal implications arising from the findings, the Coroner will exercise discretion as to what information will be passed to the lead Paediatric Consultant and Designated Doctor for Child Deaths via Pan Cheshire CDOP. The Paediatrician may be instructed to keep some information strictly confidential.

13.14 **Within 48 hours** of the postmortem the pathologist will provide to the Coroner in writing the following information:

- The preliminary postmortem pathological findings (if any).
- The preliminary cause of death if ascertained.
- Details of tissues retained for further examination (if any).

13.15 The Coroner will brief his staff **within 72 hours** of the death with the information appropriate to share with other agencies. This information will be available to those, within the guidelines' who telephone the Coroner's office. Those receiving such information will treat the same with confidentiality.

13.16 The Investigating Officer/Designated Doctor for Child Deaths will on receipt of the full postmortem result arrange any further child death review meetings.

13.17 The pathologist will send the written post-mortem report to HM Coroner. The Coroner will authorize a copy to the Designated Doctor Children's Deaths and the Duty Consultant Paediatrician via Pan Cheshire CDOP, clealry specifying if it can be shared with the family. HM Coroners officer will furnish the investigating police officer with a copy of this report with consent of HM Coroner.

13.18 There is within these guidelines' agreement for the collection of medical samples, radiological examination, and care of intravascular and surgical lines. This must be followed, and any proposed deviation discussed with HM Coroner.

13.19 A postmortem is not subject to consent and takes place irrespective of the parents' wishes. The pathologist will inform the Coroner about the tissue samples taken during the autopsy. In relation to tissue disposal (i) ordinary paediatric postmortems - tissue subject to normal rules; (ii) forensic post mortems - tissue retained under Police and Criminal Evidence Act (PACE) and remains outside the Coroner rules whether or not the death subsequently becomes non suspicious leading to a Coroner's inquest.

13.20 Coroner's Officers will consult with the family as to the ultimate disposition of those samples, the choices being for the tissues to be preserved as part of the permanent medical record, returned to the parents (i.e., funeral director), used for the purpose of medical research or respectfully disposed of.

13.21 Mortuary staff should notify the Designated Doctor for Child Deaths and Named Nurse for Safeguarding Children of all child deaths under 18 years of age.

14. Family Engagement and Bereavement Support

14.1 An unexpected death of a child is perhaps the most devastating trauma and grief that any person can sustain. The parents go through different emotions, ranging from shock, disbelief, guilt, and anger. There is added stress posed by police investigations and pending post-mortem and the inquest. While the professionals will use the procedures and guidelines for dealing with sudden unexpected death of a child, for parents it is perhaps the first and only life-time tragic experience; each component of this experience is very traumatic. Any minor aberrations or deviations of the observed process add to this trauma. Hence it is of paramount importance that the professionals dealing with SUDIC are fully trained with the SUDIC Guidelines. Experience has taught us that lack of certain knowledge at key points can have devastating effects for the family and adversely affects their subsequent relationship with the professionals and the health care system.

14.2 Particular consideration should be given to:

- The capacity of the family to engage in the processes unfolding around them.
- Language issues, health, or mental capacity.
- Faith and religious culture of child and family

14.3 Where English is not the first language, every attempt should be made to provide translation/interpreting services, including out of hours. Children should not be used as an interpreter for the family.

14.4 The professionals and the parents/carers meet at certain strategic points and these need to be kept within strict professional boundaries.

14.5 There is no place for personal views, opinions and interpretations and only factual information should be shared.

14.6 The first direct contact is likely to be with the ambulance staff. The staff, while supporting parents, can explain the factual condition of the child to the parents, the procedures being undertaken (CPR, Oxygen, etc.) and the transportation process.

14.7 As soon as the Emergency Department receives notification of an arrival a senior nurse should be assigned to act as Emergency Department Liaison Nurse and to receive and support the parents.

14.8 This nurse will take the lead in:

- Organising the communication process with the parents and must be present throughout the process of information gathering and sharing.
- Discussion with the parents/carers regarding any specific religious or cultural needs.
- Arranging parental contact with the senior paediatrician after the resuscitation has been discontinued.
- Will arrange and support the parents during their contact with the deceased child.

14.9 The nurse will also ensure that parents receive an explanation and are given leaflets about:

- Hospital Trust and the regional (Alder Centre, Liverpool) bereavement and counselling support.
- National Parent Support groups such as the Lullaby Trust.
- Child Death Review process (a guide for parents).

14.10 The family should be told at an early stage that, because their infant's death was unexpected, the coroner will need to be informed and there will need to be a police investigation. This must be explained to the family in a sensitive way, emphasising that these are routine procedures that are followed in any unexpected infant death.

14.11 The purpose and process of the joint agency response should be explained to the family, emphasising that all professionals are working together to try and help them understand why their infant has died and to support them.

14.12 The family should be informed that, as part of this process, information will be shared with their primary care team, social services, and other relevant professionals.

14.13 Unless the cause of death is immediately apparent, the family should be informed that the coroner is likely to order a post-mortem examination. The family should be informed about the post-mortem examination, including the likely venue and timing, any arrangements for moving their infant, and the likelihood that tissues will be retained during the post-mortem examination. This information should be provided in a sensitive and meaningful manner. The coroner is required by law to carry out a post-mortem when a death is suspicious, sudden, or unnatural. However, cultural, and religious issues can have a significant impact following a bereavement, particularly if there is conflict between religious customs and legal and medical requirements so it is important to have a general understanding of faith groups and cultures. If a child's death is sudden but explained and if a post-mortem is not required by the Coroner then staff may need to assist with religious faiths, cultures or parental wishes which may include preparation and early release of the body. Staff familiarity with their local standard operational procedures is essential (particularly for out of hours and weekends) (Sudden.org)

14.14 The family should be made aware that it may take several weeks to secure the results of the post-mortem examination and for the coroner to come to a conclusion. Every effort should be made to keep the family informed at each stage of the process. The family should receive regular telephone calls from either the healthcare professional supporting the family or the coroner's office to let them know how matters are proceeding. The Lullaby Trust has told us that families greatly appreciate such calls, even if this is to tell them that a further delay is expected.

14.15 Written information is important and valuable to the family because much of the detail of what is discussed can be forgotten or lost in the immediate stress of their infant's death. It is important that the family are provided with relevant and up to date information but are not overwhelmed by this. The Lullaby Trust produces a comprehensive leaflet, When a Baby Dies Suddenly and Unexpectedly, which can be shared with families at the earliest opportunity. Details of local and national support

organisations, and information about the post-mortem examination (NHS leaflet) and the child death review process by the local CDOP should also be provided to the family.

14.16 A list of Bereavement Support organisations and their contact details is provided in Appendix 2C. Most families do seek immediate support from external agencies following the unexpected death of their infant, and their involvement with the family over a period of time needs to be factored in as part of the wider multi- agency response.

14.17 The family should be clearly informed of the names and contact details of the lead professionals responsible for the joint agency response, including the lead health professional, police investigator and coroner's officer. If it becomes necessary to transfer responsibilities between professionals, the family should be informed of this and introduced to any new professionals involved.

14.18 The family must be given clear details of whom to contact, both in working hours and out of hours, should they have any questions or concerns.

14.19 Other Professionals

14.19.1 At the time of a child's death, other professionals may also provide vital support to the family; these include (but are not limited to) the GP, clinical psychologist, social worker, family support worker, midwife, health visitor or school nurse, palliative care team, chaplaincy, and pastoral support team.

14.19.2 In all cases, it is the duty of the key worker to ensure that there is clarity regarding each professional's role; that the family does not receive mixed messages; and that communication is clear.

14.19.3 In cases where Genetic studies were pursued to identify cause of death, the Genetics team must share the results and management plan with the family and consultant paediatrician for the child.

14.20 What should bereaved families expect when their child has died?

14.20.1 It should be remembered that bereaved parents may be in state of extreme shock when their child has died. They may not be able to process or retain information and it is common that information needs to be repeated over time.

The booklet, "When a Child Dies– A Guide for Parents and Carers, should be given to all bereaved families or carers:

When a child dies - A guide for parents and carers (lullabytrust.org.uk)

15. References

1. Child Death Review Statutory and Operational Guidance (England), HM Governance, October 2018

2. Sudden Unexpected Death in Infancy: A Multi-Agency Protocol and Investigation (Chair Baroness Helena Kennedy), Royal College of Paediatrics and Child Health 2004

3. Royal College of Paediatrics and Child Health Guidance on Child Death Review Process 2008

4. Preventing Childhood Deaths: A Study of 'Early Starter' Child Death Overview Panels in England, Department for Children, Schools and Families, University of Warwick, 2008

5. Working Together to Safeguard Children 2023: statutory guidance

6. Confidential Enquiry into Maternal and Child Health – Why Children Die: A Pilot Study, NCB 2006

7. Sudden unexpected death in infancy and childhood multi-agency guidelines for care and investigation. The report of the working group convened by The Royal College of Pathologists and endorsed by The Royal College of Paediatrics and Child Health. Chair: The Baroness Helena Kennedy QC, 2nd edition, November 2016.

8. Wood Report 2016 Review of the role and functions of Local Safeguarding Children Boards. Department for Education

9. National Quality Board 2018 (1st Ed) Learning from deaths. Guidance for NHS trusts on working with bereaved families and carers.

10. National Children's Hospitals Bereavement Network September 2020. Bereavement Standards www.togetherforshortlives.org.uk/app/uploads/2020/09/V4.2-Bereavement-Standards.pdf

11. Report the death of a child over 4 years of age with a learning disability or an autistic person. https://leder.nhs.uk

Appendix 2A - SUDIC Contacts

CHILD DEATH NOTIFICATION (previously Form A) to be sent via e-CDOP link

www.ecdop.co.uk/PANCheshire/Live/Public

to CDOP Administrator

cdop@mcht.nhs.uk

TELEPHONE NUMBER: 01270 826060

To report a death / seek advice, contact the Coroner's Office:

All Areas (Crewe, Chester, Macclesfield, Halton & Warrington

All contact with a coroner during office hours (0830-1630 Monday to Friday only) should be made to the main coroner's office on 01925 444216 in the first instance and the call will be transferred by the admin team to the coroner on duty.
01925 444216 – direct in-hours number for duty coroner, for urgent matters only

Calls outside of office hours should be made to the on-call out of hours phone (07970 112980) and will be dealt with by the coroner on call.

Senior Coroner - Ms Jacqueline Devonish (Coroner Devonish)
Main office (during office hours 0830-1630 Monday to Friday only)
On-call/out of office hours: 07970 112980

Area Coroner - Mrs Victoria Davies
Main office (during office hours 0830-1630 Monday to Friday only)
On-call/out of office hours: 07970 112980

Coroner's Officer Manager - Detective Inspector Darren Reid
Direct line: 01606 365227
Mobile: 07929 769596
Police Team: 01606 363892

HMC Coroner's Team Manager - Laura Jukka
Direct line: 01925 442107
Email address: ljukka@warrington.gov.uk

Coroner's Officers (Monday-Friday 8am-4pm):
01606 363 892

Designated Health Professionals Warrington & Halton
Designated Doctor for Child Deaths:
Dr Kate Hunter
TEL NO: 01925 662215 (In hours)
e-mail: kate.hunter2@nhs.net
CDOP Specialist Nurse: Sarah Rhodes
TEL NO. 01925867877; 07464521207;
alwch.warringtonsafeguardingteam@nhs.net

Cheshire East (Crewe and Macclesfield District)

Designated Doctor for Child Deaths:
Dr Arumugavelu Thirumurugan
TEL NO: 01270 273016 (In hours)
e-mail:
arumugavelu.thirumurugan@mcht.nhs.uk
CDOP Specialist Nurse:
Janice Bleasdale
MOBILE NO: 07741 010973 (In hours)
email:
janice.bleasdale@cheshireandmerseyside.nhs.uk;
Cheshire.eastsafeguardingadmin@cheshireandmerseyside.nhs.uk
Designated Nurse Safeguarding children/CiC
Nicola.wycherley@cheshireandmerseyside.nhs.uk;

Cheshire West & Chester
Designated Doctor for Child Deaths:
Dr Rajiv Mittal
TEL NO: 01244 362083 (In hours)
e-mail: rmittal@nhs.net
CDOP/Specialist Nurse: Janice Bleasdale
MOBILE NO: 07741 010973 (In hours)
email:
janice.bleasdale@cheshireandmerseyside.nhs.uk;
cheshire.westsafeguardingadmin@cheshireandmerseyside.nhs.uk
Designated Nurse Safeguarding children/CiC
Sue.pilkington@cheshireandmerseyside.nhs.uk;

Appendix 2B - Notification of Child Death

(To be completed by the Emergency Department/Paediatric Nurse)

All child deaths / cases of ALTE that are unexplained and/or suspicious, requiring resuscitation and intensive care must be notified to Pan Cheshire Child Death Overview Panel (CDOP). Child deaths must be notified via eCDOP, that can be accessed using the following link, by frontline staff dealing with the child death.

www.ecdop.co.uk/PANCheshire/Live/Public

eCDOP is the electronic portal for child death notifications (previously completed on Form A). As a minimum, staff must in addition notify Child Health Computer, GP and Named Nurse for Safeguarding Children locally. This is to avoid any delays in key staff being notified by CDOP as CDOP is not staffed on certain days of the week.

Upon receipt of notification, CDOP must ensure the child death is communicated to all relevant personnel including child death lead contacts within each Cheshire area and the Child Health Computer (CHC) staff at the earliest.

CDOP should then send an email request to all relevant professionals to complete the Reporting Form (previously known as Form B), electronically on eCDOP, that would inform the review of the child death by CDOP.

For deaths in children who are not normally resident in Cheshire, Pan Cheshire CDOP would notify the relevant CDOP where the child is normally resident.

For out of area deaths of children normally resident in Cheshire, the CDOP area where the child died should notify Pan Cheshire CDOP. The same applies to child deaths in the devolved nations, of a child normally resident in Cheshire. Overseas child deaths should be notified to the CDOP where the child is normally resident by the Foreign Commonwealth Office.

Cases of **ALTE** that are unexplained and/or suspicious, requiring resuscitation and High Dependency / Intensive care should be notified to Pan Cheshire CDOP via e-mail at cdop@mcht.nhs.uk

Appendix 2C - Bereavement Support and Resources

In Pan Cheshire many of our Infants and children either die at Alderhey NHS Trust or following a SUDIC are taken to Alderhey for Postmortem so families will automatically be supported and guided through the processes by a **KEY** worker from the Snowdrop team based at the Aldercentre, Alderhey. 2Wish are a charitable organisation that also provide support following a SUDIC and a **KEY** worker can support the family. Parent/carer consent needs to be obtained and a referral sent for this service (see referral in appendices).

The Aldercentre (Alderhey) following a child death – The Snowdrop Team at the Aldercentre provide a 24hr, 365 days a year response to families whose child dies at or is taken to Alderhey following their death. Bereavement care workers are available to support the family within an hour of a child's death and in the weeks following. The team liaise with medical and nursing staff, police, coroners and funeral directors and provide emotional and practical support and debriefs where appropriate and will sign post to other organisations if required.
T: 0151 252 5391
www.alder.centre@alderhey.nhs.net

Child Death Helpline (Alder Centre)
Bereavement counselling for anyone affected by the death of a child (regardless of age)
T: 0800 800 6019

2wish- Cheshire
Support to anyone affected by the sudden and unexpected death of a child or young person aged 25 and under.
T: 01443 853125
support@2wish.org.uk

Help is at Hand
A resource for people bereaved through suicide or other unexplained death, and for those helping them.
www.supportaftersuicide.org.uk/resource/help-is-at-hand/

Bliss
Support, including after bereavement, for the family of a premature baby.
T: 020 7378 1122
www.bliss.org.uk
hello@bliss.org.uk

Childhood Bereavement Network
Information and advice about local and national services to support bereaved children and young people.
www.childhoodbereavementnetwork.or.uk

Hope Again/Cruse
A dedicated website designed to support young people after the death of someone close.
www.hopeagain.org.uk

Cruse
Bereavement support
T: 0808 8081677
www.cruse.org.uk

HM Coroner – Guide to coroners services
https://assets.publishing.service.gov.uk/media/5e258ec240f0b62c52248094/guide-to-coroner-services-bereaved-people-jan-2020.pdf

Compassionate Friends
Support for bereaved parents, siblings, and extended family.
Tel: 0345 123 2304
www.tcf.org.uk

The Lullaby Trust
Bereavement support
T: 0808 802 6868
www.lullabytrust.org.uk/bereavement-support

Brake
Support following bereavement or injury sustained from a Road Traffic Collision
T: 0808 8000401
www.brake.org.uk

Road Peace
A national charity for road crash victims
T: 0800 1601069
www.roadpeace.org

Sands
Supports anyone affected by the death of a baby.
T: 0808 164 3332
www.sands.org.uk

Winstons Wish
Support bereaved children, teenagers and young adults (up to the age of 25)
Available 8am-8pm weekdays.
T: 08088 020 021
www.winstonswish.org

Child Bereavement UK (Cheshire)
For support when a child grieves, or child dies, up to the age of 25.
T: 01928 577164 (Widnes)
T: 0800 028 8840 (National)
northsupport@childbereavementuk.org
www.childbereavementuk.org

The Good Grief Trust
Help and Hope in one place
www.thegoodgrieftrust.org.uk

When a Child Dies
A Guide for parents and carers
www.lullabytrust.org.uk/wp-content/uploads/parent-leaflet-child-death-review.pdf

Appendix 2D - Guide to the assessment of the environment and circumstances of death during joint visit to scene of death

1. As soon as possible after the infant's death, an appropriate health professional, preferably who has already met the family (Health visitor, On-call Paediatrician, Specialist CDOP Nurse or Designated Doctor for Child Deaths) and police investigator, accompanied by the family's GP if possible, should visit the family at home or at the site of the infant's collapse or death.

2. The purpose of this visit is to obtain further, more detailed information about the circumstances and environment in which the infant died, and to provide the family with information and support.

3. This visit should normally take place within daylight hours. If there is likely to be a delay in arranging the joint visit, the police investigator should consider whether the police should carry out an initial visit to review the environment, ascertain whether there are any forensic requirements and appropriately record what is found. Unless there are clear forensic reasons to do so, the environment within which the infant died should be left undisturbed so that it can be fully assessed jointly by the police and health professionals, in the presence of the family.

4. The lead health professional with the police investigator should inform the family of the nature and purpose of this home visit. Time should be allowed for the family to go at their own pace, respecting that they may find it difficult to talk through the events or go into the room where the infant has died. Allowance should be made for others, such as grandparents or family friends, to be present to support the parents.

5. The lead health professional with the police investigator should review the key elements of the history, allowing the family to elaborate on any particular aspects and to clarify any points that were unclear or missing from the initial history. Particular note should be made of any observations made by the family in the days before the infant's death. They may have taken photographs or video clips on a mobile phone that could shed light on the infant's state before death.

6. When the family is ready, the police investigator and lead health professional should review the environment where the infant died. It can be very helpful at this stage for appropriate family members to be present to describe in detail the final events, how the infant was put to sleep and how they were found.

7. Consideration should be given to reconstruction of the sleeping environment, for example, with the use of a doll or prop. There is no strong evidence that this provides a more accurate understanding of the mode or circumstances of death, but it may prove helpful, particularly if the account is not clear, or if there are indications of possible overlaying or asphyxiation. Anatomically proportioned dolls are available for this purpose, or the family could use a cuddly toy to illustrate how and where the infant was lying. Care should be taken not to further distress the family if a reconstruction is required.

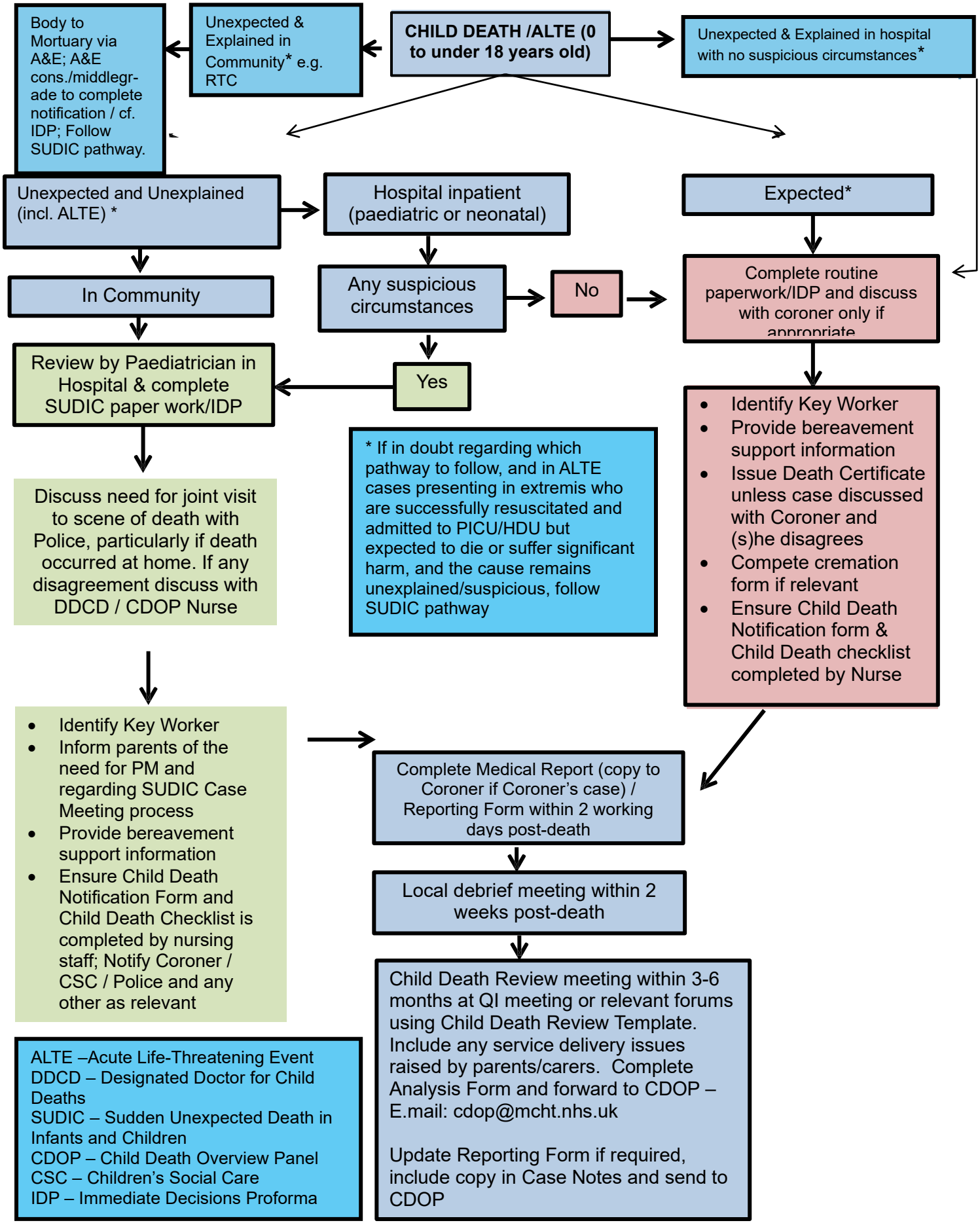
8. The police lead investigator should consider whether to request crime scene investigators to take photographs or a video of the scene of the infant's death, and whether any items should be seized for further forensic investigation. Other possible relevant recordings, such as room temperature, are detailed within the police-approved professional practice guidance for investigators. It is rarely necessary to seize bedding or clothing, and these rarely add anything to the investigation. However, there may be circumstances when an infant's cot or other sleeping environment needs to be taken for further examination. This should only be taken after the joint visit, so all items can be seen first in situ. Similarly, there may be circumstances where an infant's feeding bottle or other feeds or medications need to be taken for further analysis.

9. After reviewing the information, the lead health professional and police investigator should discuss their findings with the family, taking care not to jeopardise any further investigation if there are concerns around possible abuse or neglect. The family should be informed of the further investigations that will need to be carried out, including the post-mortem examination, and how and when they will be informed of the results.

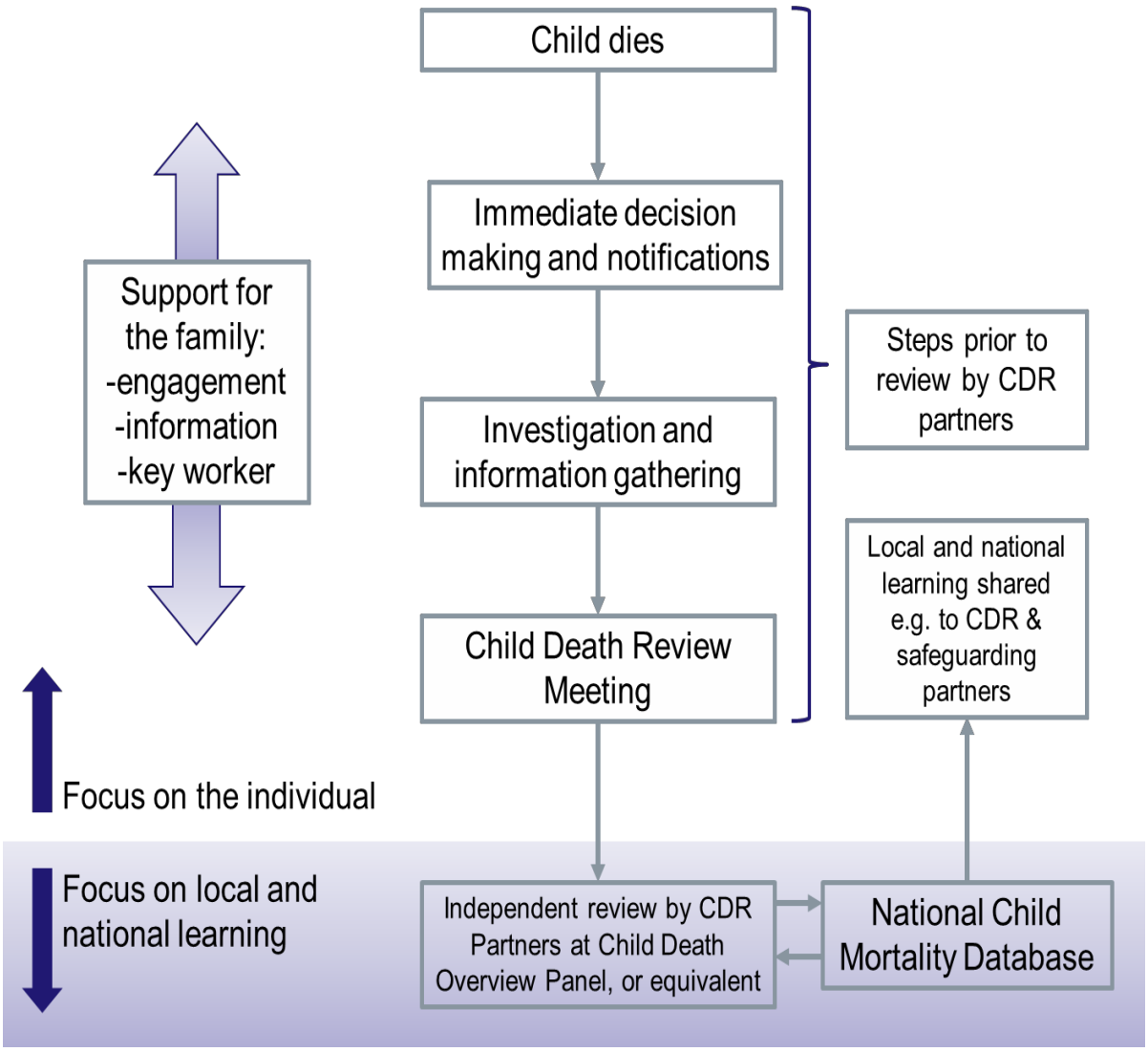
10. Information may be given to the family at this stage, in general terms, around possible causes of unexpected infant death. It is important, however, to emphasise that it is not possible to give a definitive cause of death until all investigations are complete, and that the ultimate decision on the cause of death rests with the coroner.

11. The family should be given clear information about who they can contact for support or advice, including contact details for local bereavement support and relevant local or national organisations such as The Lullaby Trust (Appendix 2C)

Appendix 2E - Quick reference guide to Child Death / ALTE process



Appendix 2F - Child Death / ALTE Procedures



Appendix 2G – SUDIC Initial Case Discussion (Joint Agency Response / Rapid Response) Meeting

CONFIDENTIAL

Initial SUDIC Case Discussion (Joint Agency Response / Rapid Response) Meeting

SUBJECT NAME	
DATE OF BIRTH	
DATE OF DEATH	
MEETING DATE	
MEETING VENUE	
CHAIRPERSON	
TIME COMMENCED	
TIME CLOSED	

Present

Initials	Name	Designation	Organisation

Apologies

1 Chairperson introduction & confidentiality clause
Confidentially **Clause** **Chairperson** [Chairperson] reiterated to all attendees that all information from this meeting is confidential and should not be released to any other agencies / individuals, repeated, copied or disclosed following the meeting without the consent of [Chairperson]. Copies of the minutes will be sent to the Pan Cheshire CDOP e-mail cdop@mcht.nhs.uk and the Coroner. Proceedings of the meeting maybe audio recorded to assist with compiling the minutes and will be deleted after the minutes have been finalised.
2 Introductions
3 Family details verified
Deceased child: - (name & DOB & DOD) Father: - (name & DOB) Mother: - (name & DOB) Siblings: - (names & DOB) Home address: Contact: - (home) (mobile) Religion: -

4 Purpose of meeting outlined
• To collate all relevant information • For each agency to share information from previous knowledge • To identify the cause of death and/or factors that may have contributed to death • To identify any lessons learnt from this process • Decide what should happen next • Consider any child protection risks to siblings and others • To ensure coordinated bereavement and care plan • To consider staff welfare and support • The information from this planning meeting may be made available to the coroner
5 Relevant information
(Available from police notes)
6 Post Death Examination
(Available from consultant that conducted post death examination – held in patient notes)
7 Medical view / clarifications
8 Samples taken by the hospital
Blood/Urine/Microbiology/Swabs/Imaging Forensic samples from parents/carers
9 Information from each agency
Videos and photographs of the scene of death taken by the Police should be shared. Relevant information should be shared from each agency with previous knowledge of the family and records, including, any reference to the circumstances of the child's death; previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family; neglect, failure to thrive, parental substance abuse, mental illness or domestic violence. Information is also required about family members and others involved with the child. Police CSC Community Health Hospital GP Ambulance Education Other
10 Preliminary postmortem findings
The SIO will share the preliminary PM report if available
11 Coroner information
Name of Coroner Date re. release of body, if applicable Cause of death if known Inquest – Y/N Death Certificate – issued Y /N
12 Bereavement Support for family
Appropriate professional identified to offer the family support or to refer or signpost to appropriate bereavement agencies/counselling; Identify Key Worker/Case Manager as relevant. Arrangements will be made for parents/carers to attend an appointment to discuss the medical reports when the final medical investigations are completed.

13 Bereavement support for peers at school if relevant
Educational Psychologist/Critical Incident Team/School Nurses
14 Consider each agency re staff welfare and support
• ED Managers and Paediatric Matron aware of events and will support staff involved. • Police - involved to be supported. • Health Visitor / School Health Advisor • School • Ambulance – Paramedics involved to be supported • Additional professionals
15 Lessons identified / issues to be addressed / good practice
16 Discuss SUDIC procedures (eCDOP Notification, Reporting Forms, Coroners reports, etc.)
17 Discuss if Referral is required or being undertaken for an internal or external investigation
Referral for Serious Child Safeguarding Incident Notification is required: **Y/N** Is an internal/external Agency led investigation being considered i.e.: RCA **Y/N** Is a referral required to the HSIB (Healthcare Safety Investigation Branch) **Y/N** Is a referral for child safeguarding Practice review needed **Y/N**; If yes, by whom? Please include rationale for decision either way. Does the case meet criteria for referral for LeDeR (child over 4 yrs. of age and had a Learning disability)? If yes, refer via https://leder.nhs.uk/report
18 Date of final multiagency meeting
Agree when a follow-up case discussion meeting will be held after final PM report available, generally within the subsequent six to twelve months
19 Any other business
e.g. Press strategy
20 Summary of Actions / By Whom / By When / Update on completed actions including who says what to family

Appendix 2H – Working Arrangements Between Pan Cheshire Child Death Overview Panel (CDOP) And Cheshire Coroner's Court

Role of Pan-Cheshire CDOP

1. Inform the Coroner regarding any proposed policy changes in the management of Sudden Unexpected Death in Infancy and Childhood (SUDIC) by sharing each iteration of the Pan Cheshire SUDIC Guidance document;

2. Provide the Coroner with a copy of the Pan-Cheshire COOP annual report;

3. Ensure that clinicians are aware that:

   a. Child deaths are reportable to the Coroner as per criteria outlined in the Notification of Death Regulations 2019;

   b. The death must always be reported if there appears to be "any concerning feature";

   c. If a clinician is unsure whether a death must be reported to the Coroner's Court, he/she should telephone the Coroner's Office for guidance;

4. Ensure that clinicians are aware that the means of contacting the Coroner out-of-hours is by calling the duty telephone number 07970 112980. This number is to be used when:

   a. There is a concerning feature to a death and the clinician requires ***either*** coronial guidance on the next steps ***or*** *a* decision from the coroner, ***and***

   b. That guidance or decision cannot wait until the next working day.

Cheshire Coroner's Court

5. Will use best endeavours to work collaboratively with CDOP to share relevant information about child deaths reported to the Coroner for the sole purpose of learning lessons from and prevention of future deaths. This collaboration will depend upon the resources available to HM Coroner. Detective Inspector Darren Reid may attend CDOP meetings on behalf of HM Coroner to keep the panel apprised of reported deaths and outcomes.

6. HM Coroner may disclose to Pan-Cheshire CDOP and the respective Designated Doctor for Child Deaths (DDCD) the results of post-mortem examinations in cases of child deaths to facilitate Final Child Death Review Meetings to be convened;

7. Inquest conclusions in cases of child deaths can be made available upon request;

8. Pan-Cheshire CDOP may access reports to prevent future deaths in accordance with Paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 via the Public Tracker Platform on https://preventabledeathstracker.net/

HM Coroner
28 April 2024

Appendix 2l - Final SUDIC Case Review minutes

CONFIDENTIAL

Initial SUDIC Case Discussion (Joint Agency Response / Rapid Response) Meeting

SUBJECT NAME	
DATE OF BIRTH	
DATE OF DEATH	
MEETING DATE	
MEETING VENUE	
CHAIRPERSON	
TIME COMMENCED	
TIME CLOSED	

Present

Initials	Name	Designation	Organisation

Apologies

1 Chairperson introduction & confidentiality clause
Confidentially **Clause** **Chairperson** [Chairperson] reiterated to all attendees that all information from this meeting is confidential and should not be released to any other agencies / individuals, repeated, copied or disclosed following the meeting without the consent of [Chairperson]. Copies of the minutes will be sent to the Pan Cheshire CDOP e-mail cdop@mcht.nhs.uk and the Coroner. Proceedings of the meeting maybe audio recorded to assist with compiling the minutes and will be deleted after the minutes have been finalised.
2 Introductions & aims of the meeting
Key Worker, Police, CSC, Community Health, Hospital, GP, Ambulance, Education
3 Minutes of the last meeting

Were the minutes of the last meeting approved?	Yes / No

4 Amendments

5 Matters arising from previous meetings including SUDIC Initial Case Discussion (Rapid Response) Meeting
6 Review of Actions from previous multi-agency meetings
7 Agency feedback and results of final PM shared
Identify appropriate professional to arrange appointment with parents to discuss results of final PM.
8 Continued support of family and peers
9 Staff Welfare and Support
10 Lessons identified/Examples of Good Practice
12 Issues for Discussion and/or Escalation within/across Agencies and to CDOP/Child Safeguarding Partnerships/Coroner including need for consideration for Serious Child Safeguarding Incident Notification for Child Safeguarding Practice Review/Referral to HealthCare Safety Investigation Branch
13 Analysis Form
14 Any other business
15 Summary of further actions

No	Action	By whom	By when	Update of action and date

Appendix 2J - Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP)

PAN CHESHIRE CHILD DEATH OVERVIEW PANEL

Partners – Halton, Warrington, Cheshire East, Cheshire West & Chester

Tel: 01606 288923 Cdop@mcht.nhs.uk

This analysis form should be read in conjunction with the collated reporting form, and the PMRT in babies who die on a **neonatal unit, delivery suite or labour ward**, to provide relevant information on the child, the circumstances of their death, and factors identified in any of the relevant domains.

Using this form at the Child Death Review meeting
Information gathered from the different agencies should be made available to the Child Death Review meeting by the relevant CDOP administrator. Drawing on the intelligence gathered, those present at the child death review meeting should then appraise all the relevant information in order to form an understanding of the circumstances of the child's death, identify any modifiable factors and lessons to be learnt, and any action that will be taken at a local level. The completed Analysis form from the Child Death Review meeting should then be submitted to the CDOP.

Using this form at the Child Death Overview Panel meeting
The completed form from the Child Death Review meeting, along with any additional information gained from other agency sources should be presented in anonymised form to the CDOP. Drawing on the intelligence gathered, those present at the CDOP should appraise the relevant information in order to affirm that the understanding of the circumstances of the child's death is correct, that appropriate modifiable factors and lessons have been identified, and decide upon any actions to be taken across agencies or networks of care.

Child Death Review Meeting date: / /
Return all completed forms to: cdop@mcht.nhs.uk

CDOP Meeting date: / /

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

Individuals/ Departments/ agencies represented* at CDR meeting / CDOP:

☐ Admin or Clerical	☐ Mental Health Services	☐ Primary Health Care
☐ Ambulance Services	☐ Midwifery	☐ Risk Manager or Governance Team
☐ Bereavement Team	☐ Neonatal Nurse	☐ Safety Champion
☐ Children's Social Care	☐ Neonatology	☐ Schools
Services	☐ Obstetrics	☐ Hospital Services
☐ External	☐ Management Team	☐ Police
☐ Paediatrics	☐ Palliative Care Services	☐ CCG
☐ Public Health	☐Other (please specify)	

** Including reports submitted by professionals and agencies unable to attend meeting in person*

Additional agency reports provided for purposes of CDOP review:

The review meeting should analyse any relevant factors that may have contributed to the child's death. In doing so you might take into account those issues that have been highlighted in the Reporting Form. For each of the four domains below, list the factor, assign a group and subgroup (see Contributory Factors Guidance) and determine the level of influence (0-2):

0 - Information not available
1 - No factors identified, or factors identified but are unlikely to have contributed to the death
2 - Factors identified that may have contributed to vulnerability, ill health or death

This information should inform the learning of lessons at a local level.

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

Domain A: Factors intrinsic to the child. Please list factors in the child (and in neonatal deaths, in the pregnancy). Consider factors relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.				
			CDOP affirmation	
Factor	**Relevance (0-2)**	**Is this factor to be modifiable?**	**Relevance (0-2)**	**Is this factor deemed by CDOP to be modifiable?**
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				

Domain A: Factors intrinsic to the child

Groups	Child health History / medical conditions	Risk factors in mother during pregnancy / delivery	Childs Developmental conditions / disabilities	Emotional / behavioural factors	Smoking / alcohol Substance user / Misuse by the child	Child health History / medical conditions
Subgroups	Prematurity	Twin/multiple Pregnancy	Learning disability	Mental health condition		Prematurity
	Low birth weight	Assisted conception	Sensory impairment	Risk taking behaviour	Child consumed alcohol regularly / known to binge drink	Low birth weight
	Bottle-fed	High maternal BMI	Motor impairment	Suicidal or self-harm ideation	Child consumed drugs on day of death	Bottle-fed
	Breast-fed	Low maternal BMI	Other developmental Impairment or diability	Poor or non-compliance of medication	Child was known to be a regular drug user	Breast-fed
	Acute sudden onset illness	Smoking in pregnancy	Neurodevelopment conditions	Sexual orientation / Identity Or gender identity	Child smoke tobacco / e-cigarette	Acute sudden onset illness
	Chronis health Condition	Substance misuse in pregnancy		Loss of key Relationships		
	Malignancy / Cancer	Alcohol misuse in pregnancy		Isolation from family / friends / support		
	Congenital / Genetic / chromo-sonal condition	Perinatal mental health condition		Social media / internet use		
	Child not fully immunised (regardless of reason)	Maternal diabetes / Gestational diabetes				
		Maternal age				
		Maternal infection				
		Late booking / concealed pregnancy				

Groups	Child health History / medical conditions	Risk factors in mother during pregnancy / delivery	Childs Developmental conditions / disabilities	Emotional / behavioural factors	Smoking / alcohol Substance user / Misuse by the child	Child health History / medical conditions
		Other obstetric complications				
		Delivery complications				

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

Domain B: Factors in social environment including family and parenting capacity. Please list factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.				
			CDOP affirmation	
Factor	**Relevance (0-2)**	**Is this factor to be modifiable?**	**Relevance (0-2)**	**Is this factor deemed by CDOP to be modifiable?**
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Please also describe positive aspects of social environment and give detail to examples of excellent care:				

Domain B: Factors in social environment including family and parenting

Groups	Smoking / Alcohol / Substance misuse by parent/carer	Challenges for parents with access to services	Domestic or child abuse / Neglect	Household Functioning	Poverty & deprivation
Subgroups	Parent / carer has consumed alcohol around the time of the child's death	Parental non-engagement with any service	Child was subject to physical abuse by an adult	Complex home circumstances	Income deprivation
	Parent/carer known for alcohol misuse	Child was not brought to appointment(s) Did not attend	Child was subject to sexual abuse by an adult	Lack of appropriate supervision	Employment deprivation / unemployment
	Parent / carer had consumed drugs around the time of the child's death	Evidence of disguised compliance by parents in any service	Child was subject to emotional abuse by an adult		Health Deprivation and disability
	Parent / carer known for substance misuse	Delay in seeking / failure to seek medical advice	Child was subject to neglect by an adult		Barriers to services
	Parent / carer smoked tobacco/e-cigarettes in the household		Other known domestic violence / abuse in the household		

Domain B: Factors in social environment including family and parenting continued

Groups	Social care	Cultural Factors	Parents / Carers health	School / Peer group	Other
Subgroups	Child on child protection plan at time of death	English not parents first language	Mental health condition in a parent/carer	Exclusion / suspension from school	
	Child on child in need plan at time of death	Parents are / were refugees / asylum seekers	Physical health condition in a parent / carer	Truancy/poor attendance record	
	Child was a looked after child at time of death	Close relative marriage (consanguineous)	Disability in a parent / carer	Gang / knife crime	
	Child was previously known but not an open case		Learning disability in a parent/carer	Drug use in peer group	
	Child was a refugee / asylum seeker			Other school / peer group related factor	
	Parent was a care leaver				
	Other social care factors				

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

Domain C: Factors in the physical environment. Please list issues relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy. Include poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g., burns, falls, road traffic collisions).				
			CDOP affirmation	
Factor	**Relevance (0-2)**	**Is this factor to be modifiable?**	**Relevance (0-2)**	**Is this factor deemed by CDOP to be modifiable?**
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				

Domain C: Factors in the physical environment

Groups	Sleep Environment	Home safety/conditions	Vehicle collision	Public Safety	Other
Subgroups	Unsafe sleeping arrangements	Overcrowded living conditions	Speeding vehicle / Recklessness	Absent / non-visible warning signs	
	Co-sleeping	Dirty, mouldy or property in poor repair	Young child not appropriately restrained in car seat / booster seat	Unsafe street Furniture / public equipment	
		Unsafe appliances / Environment	Child not using other appropriate safety equipment	Availability of safety equipment	
		Attack by pets/animal	Unsafe road conditions	Accessible railway tracks / other infrastructure	
		Living environment deprivation / homelessness	Other factors	Accessible water	
				Poor compliance with health & safety regulations	

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

Domain D: Factors in service provision. Please list any issues in relation to service provision or uptake. Include any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.				
			CDOP affirmation	
Factor	**Relevance (0-2)**	**Is this factor to be modifiable?**	**Relevance (0-2)**	**Is this factor deemed by CDOP to be modifiable?**
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Group:		**Sub group:**		
Details:				
Please also describe positive aspects of service delivery and give detail to examples of excellent care:				

Domain D: Factors in service provision

Groups	Initiation of treatment / Identification of illness	Following guidelines / Pathway / policy	Access to appropriate services	Staffing / bed / capacity / equipment	Communication within or between agencies	Communication with family	Other
Subgroups	Issue in diagnosis	Guideline / policy / Pathway available but not followed	Issue with or lack of transfer of child	Staffing capacity or inappropriate skill mix	Poor communication / information sharing with an agency	Poor communication between professionals & family	
	Issue with availability of information	Guideline / policy / Pathway unclear or unavailable	Child not born in appropriate setting	Bed/cot Capacity	Poor communication / Information sharing between agencies	Poor information sharing with family	
	Issue with treatment, including delays	No referral / Assessment / review undertaken	Service uncommissioned / unfunded / un-available	Equipment related issues	Poor documentation	Information provided to parents was inappropriate	
	Lack of recognition of deteriorating child / clinical symptoms / signs	Poor quality referral / assessment / review	Availability/ Accessibility of medication			Lack of interpreter availability / use suitability	
	Lack of escalation for senior review	Delayed referral / Assessment / review	Transition between paediatric & adult service				

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

Consider whether the Review has identified one or more factors across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths	**CDR Review**	**CDOP affirmation**
Modifiable factors identified – please list these below *(Please also ensure these factors are listed under each domain and are indicated as modifiable)*	☐	☐
No modifiable factors identified	☐	☐
Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*	☐	☐
List of modifiable factors identified:	☐	☐

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

In light of your consideration of the case categorise the likely cause of death using the following schema.

This classification is hierarchical. **All relevant categories should be ticked if more than one category could reasonably be applied.** The uppermost ticked category will be recorded as the primary category and others as secondary categories.

Category	Name and description of category	Tick box below	CDOP affirmation
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children. **Please choose from the sub-categories below:**		
2 (i)	**Suicide (where the panel feels the intention of the child was to take their own life)**	☐	☐
2 (ii)	**Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life)**	☐	☐
2 (iii)	**Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)**	☐	☐
3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. Excludes Deliberately inflicted injury, abuse or neglect (category 1).	☐	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death	☐	☐

Category	Name and description of category	Tick box below	CDOP affirmation
	was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.		
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	☐	☐
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week). **Please choose from the sub-categories below:**		
8 (i)	**Immaturity/Prematurity related**	☐	☐
8 (ii)	**Perinatal Asphyxia (HIE and/or multi-organ failure)**	☐	☐
8 (iii)	**Perinatally acquired infection**	☐	☐
8 (iv)	**Other (please specify)**	☐	☐
9	I**nfection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐	☐

Cause of death:
In light of your review of this case, what is your opinion as to the likely cause/causes of death? Please indicate if this differs in any way from the registered cause of death or that assigned by the pathologist/coroner. Where possible, please express this in terms of the levels provided on the Medical Certificate of Cause of Death (MCCD) /neonatal MCCD.

Child Death Review Analysis Form

CDOP Identifier (Unique identifying number assigned by CDOP) ……..

Learning points and issues identified in the review:
List the learning points identified by the review group. A list of issues may include the absence of certain key persons from the discussion or the lack of key documents.
CDOP affirmation and reflection on learning points pertaining to wider agency, regional, and national bodies.
Did the panel identify any specific issues following the review of the death for immediate national alert and action that should be highlighted to NCMD? If yes, please specify:
Actions: **Identify any local actions, the department or agency responsible, and the timeline to completion. This should include those interventions deemed achievable that determined contributory factor to be modifiable.**
CDOP affirmation: **Identify any CDOP actions and/or recommendations at an agency, LSCB, regional or national level. This should include those interventions deemed achievable that determined contributory factor to be modifiable.**
Summary of ongoing support needs (including bereavement) and follow-up plans for the family and (where relevant) involved professionals

Issues identified in the review

List the issues identified by the review group. This list may include the absence of certain key persons from the discussion or the lack of key documents.

ACE – Definitions and prevalence		
Physical Abuse	is any intentional use of physical force against a child that results in, or the potential to result in, physical injury	
Sexual Abuse	Any completed or attempted sexual act, sexual contact with, or exploitation of a child by a care giver	
Emotional Abuse	Intentional care giver behaviour that conveys to a child that they are worthless, flawed, unloved, unwanted, endangered or valued only in meeting another's needs	
Neglect	Failure by caregiver to meet child's basic physical, emotional, health or educational needs – or a combination of these	
Domestic Violence	Any form of verbal or physical violence between a caregiver and his or her partner or ex-partner	
Parental Separation	Divorce or separation between parents or caregivers	
Substance Misuse	Living with a parent or caregiver or other family member who misuses substances, including illegal drugs and prescription medications	
Alcohol Misuse	Living with a parent or caregiver or other family member who misuses alcohol	
Mental Health Issues	Living with a parent or caregiver or other family member who is depressed, has other mental health problems, or who has ever attempted suicide	
Incarceration	Living with a parent or caregiver or other family member who is/ has been sentenced to serve time in a prison or youth offending institution	

Return all completed forms to: cdop@mcht.nhs.uk

Appendix 2K – Child Death Checklist – a Template

(To be used in conjunction with The Pan Cheshire Management of SUDIC/ALTE Guidelines 2023)

"The deceased child should never be left unattended, and a member of staff should always accompany the child, ideally. This is particularly important for sudden unexpected deaths or where there are suspicious circumstances. Any requests from bereaved carer(s) for privacy with their child should be handled with sensitivity. If in doubt, discuss with Police / Senior colleague."

Name of Nurse completing form:	
Signature:	
Date:	
Name of Consultant completing form:	

Please use the hospital sticker if available

Baby's name:	Parent / Carer's names:
Address:	Mother:
	Father:
Home phone number:	
Mobile phone number:	
Date of birth:	
Date of death:	
Consultant Paediatrician:	
Consultant Emergency Medicine:	

Action	R	C	Comment	Sign / Date
Is the death suspicious or not (Please ask the Police prior to completing this)? Police Officer's ID:				
Mother informed of death by				
Father informed of death by				
Interpreter if necessary				
Member of staff available to support the family				
Relative's room available				
Members of staff informed to show relatives/family to appropriate room.				
Ensure that the family has access to refreshments, telephone, toilets and car parking.				
Address families religious, cultural beliefs. Offer blessing chaplain etc. if required.				

Action	R	C	Comment	Sign / Date
Address needs of other children				
Give the family supervised access to hold the baby / infant / child young person **(with consent of Coroner/Police)**				
Explain Process of SUDIC if death fulfils the SUDIC criteria				
Parents informed about Postmortem & other investigations required.				
Postmortem form completed and signed, by parents/doctor.				
If no Postmortem is being held and the case is not a Coroner's case, and the child is planned for cremation				

Cremation form completed by two separate clinicians

Action	R	C	Comment	Sign / Date
The Consultant completing the form will:				
Inform the Consultant Paediatrician for the child				
Inform the Coroner: 01606 363892 Senior Coroner (Direct): 01925 444216 (08.00-16.00, Monday – Friday) Out of Hours: 07970 112980 (restricted to only share sensitive information that cannot wait)				
In all cases complete the Notification of Child Death via eCDOP - see Appendix 2B and inform GP, local Named Nurse for Safeguarding Children and Child Health Computer staff				

Action		R	C	Comment	Sign / Date
Inform MBRRACE Co-ordinator (C/O Labour Ward)	• Any stillbirth				
	• Any death within first 28				
	• Any baby born at less than 22 weeks gestation registered as live birth or accepted as "coroner's case"				
	• Any infant death under the age of 12 months				
	Phone – letter – email				
a) Notify the GP					
b) Antenatal and Newborn Screening Coordinator					

Action		R	C	Comment	Sign / Date
c) Notify the **Consultant Community** Paediatrician					
d) Inform the School Nurse / Health Visitor					
e) Inform the General Office					
f) Inform the Bereavement officer Can Bereavement officer attend?					
Inform the Social Worker Daytime Out of Hours					

Action	R	C	Comment	Sign / Date
Police (PPU) for (SUDIC ONLY)				

Postmortem / funeral arrangements	R	C	Comment	Sign / Date
The Consultant completing the form will:				
Discussed post-mortem exam with the parents?				
Consent given / refused (please circle)				
Other investigations requested (please detail):				
Post-mortem form completed and signed by parents and Paediatrician:				
Ensure that the Death certificate is completed, explained, and given to parents				
Stamp the health care records with cause of death if known. If post-mortem to be done, stamp in notes and fill in after post-mortem by doctors.				

Action	R	C	Comment	Sign / Date
The Nurse completing the form will:				
Clean child / baby & change baby's nappy ***(ONLY in cases when death has been confirmed as expected)***				
Arrange for the child / baby's clothing is kept				
Arrange for the child to be seen / held by mother				
Arrange for the child to be seen / held by father				

Action		R	C	Comment	Sign / Date
Arrange for the child to be seen / held by other relatives					
Check with family to be invited for a Remembrance service					
Memory box	**Name band**				
	Lock of hair (with parents'				
	Foot / handprint				
	Teddy bear				
	Sample of bath / baptism				
	Baby's clothes (store in plastic bag to retain baby smell)				

Action	R	C	Comment	Sign / Date
The Nurse completing the form will:				
Bereavement Bereavement resources cf. Appendix 2C				
Booklets: The Child Death Review – guide for parents Child Death Helpline – The Alder Centre, Liverpool Bereavement Support – Lullaby Trust 2 Wish Support Information Pack				
Obtain verbal consent from family for 2Wish support. Complete referral form-Appendix 2P				
If parents wish baby's name to be entered into the remembrance book or wish to be invited to the Remembrance Service, fill in the Teddy Bear Form and send to relevant staff member.				
Offer parents support, help or advice regarding funeral arrangements, and bereavement support.				
Give parents information about how to register a death and contact a member of the Bereavement team who will make an appointment.				

Postmortem / funeral arrangements	R	C	Comment	Sign / Date
The Nurse completing the form will:				
Arrange a de-brief for nursing staff.				
A copy of the baby's health care records to be sent to the mortuary if post-mortem is required. **N.B.** If the baby is for cremation the Paediatrician needs attend the Mortuary				

Postmortem / funeral arrangements	R	C	Comment	Sign / Date
with the baby's health care records to complete a cremation form.				

Last offices	R	C	Comment	Sign / Date
Remove all tubes, except long lines, umbilical lines and chest drains. (NB all can be removed if there is no postmortem)				
Child washed and dressed. (Not to be done if postmortem is required)				

Appendix 2L - Audit Tool for Child Death Review

1	Date of death:	
	Age of child:	Age not known
2	**Who notified the child death review team of the death?** (Tick all that apply)	
	☐ Ambulance Control ☐ Not notified ☐ Other	☐ Hospital Emergency Dept. ☐ Not known
	If other, please specify:	
3	**How soon after discovery of the death was the child notified to the team?**	
	☐ Within 2 hours ☐ Next working day ☐ Later	☐ Within 24 hours ☐ Not known
	If later, please specify:	
4	**Was an initial history taken in hospital, if so by whom?** (Tick all that apply)	
	☐ Paediatrician ☐ Police Officer ☐ Not known	☐ Emergency Department Doctor ☐ No history taken ☐ Other
	If other, please specify:	
5	**Was the child examined in hospital, if so by whom?** (Tick all that apply)	
	☐ Paediatrician ☐ Emergency Department ☐ Police Officer	☐ Child not examined ☐ Not known ☐ Other
	If other, please specify:	
6	**Were appropriate laboratory investigations carried out?**	
	☐ All investigations according to local protocol ☐ Some investigations ☐ No investigations	☐ Not appropriate ☐ Not known
	If any difficulties in carrying out investigations, what were the reasons for this?	
7	**Were the parents offered the following care and support?** (Tick all that apply)	
	☐ Allowed to hold their child ☐ Offered photographs and mementos ☐ Offered bereavement counselling or religious support ☐ Given information about the rapid ☐ Not known	☐ Offered written information ☐ Given contact numbers ☐ Informed about the postmortem ☐ Not appropriate
8	**Was an early multi-agency information sharing and planning meeting held, if so when was this held?** (Tick all that apply)	
	☐ Yes – telephone discussions ☐ Yes – sit down meeting ☐ No	☐ Same day ☐ Later (please specify) ☐ Not known
9	**Did a joint agency home visit take place?**	
	☐ Yes ☐ No	☐ Not appropriate ☐ Not known

	If so, when did this take place?	
	☐ Same day ☐ Next working day	☐ Later ☐ Not known
	If later, please specify:	
	☐ Paediatrician ☐ Police Officer ☐ Not known	☐ Emergency Department Doctor ☐ No history taken ☐ Other
	Who took part in the home visit? (Tick all that apply)	
	☐ General Practitioner ☐ SUDI Paediatrician ☐ Police Officer (Child Abuse Investigation Unit) ☐ Police Officer (other) ☐ Scenes of crime / forensic officer ☐ Other	☐ General Paediatrician ☐ Health Visitor ☐ Midwife ☐ Bereavement support worker ☐ Social worker ☐ Not known
	If other, please specify:	
	If a joint agency home visit did not take place, please specify why.	
10	**Was an autopsy carried out? If so by whom?** (Tick all that apply)	
	☐ Yes ☐ General hospital pathologist ☐ Forensic pathologist ☐ Other	☐ No ☐ Paediatric pathologist ☐ Not known
	If other, please specify:	
	If so, when did this take place?	
	☐ Same day ☐ Next working day	☐ Later ☐ Not known
	If later, please specify:	
11	**Was there a final case discussion?**	
	☐ Yes ☐ No	☐ Not yet, but planned ☐ Not known
	How long after the death did this take place?	
	☐ Within 2 months ☐ 2-4 months	☐ Later ☐ Not known
	If later, please specify:	
	If an inquest was held / planned, did the final case discussion precede or follow the inquest?	
	☐ Preceded the inquest ☐ No inquest held	☐ Followed the inquest ☐ Not known
	Who attended the final case discussion? (Tick all that apply)	
	☐ General Practitioner ☐ SUDI Paediatrician ☐ Police Officer (Child Abuse Investigation Unit)	☐ General Paediatrician ☐ Health Visitor ☐ Midwife ☐ Bereavement support worker

	☐ Police Officer (other) ☐ Scenes of crime / forensic officer ☐ Other	☐ Social worker ☐ Not known
	If other, please specify:	
	Were the family informed of the outcome of the final case discussion?	
	☐ Yes – through a home visit ☐ Yes – by telephone ☐ No	☐ Yes – by letter ☐ Yes – other ☐ Not known
12	**What was the final cause of death?**	
	☐ Death from natural causes ☐ Accident ☐ Suicide ☐ Not known	☐ SIDS ☐ Homicide ☐ Cause of death not established ☐ Other
	If other, please specify:	
13	**Were any concerns of a child protection nature identified?**	
	☐ Yes ☐ Not known	☐ No
14	**Was the case referred on to the CPS for a criminal investigation?**	
	☐ Yes ☐ Not known	☐ No

Appendix 2M – Criteria for Notification of Child Deaths to Coroner

Below is the list of deaths that require notification to Coroner. The current Coroner for Cheshire, Ms Jacqueline Devonish, has advised it is not necessary for clinicians to "discuss" all child deaths with the Coroner, as used to be the case in the past. The Coroner's office can still be contacted for queries but only in exceptional cases, where one may not be sure regarding a concerning feature (cf. last bullet point in the list below). It is no longer necessary to contact Coroner as routine for all child deaths if the doctor can provide a medical certificate for cause of death and the death does not fall within any of the below categories.

Reportable Deaths under the Chief Coroner's Guidance

- The cause of death is unknown.
- The deceased was not seen by the certifying doctor either after death or within 14 days before death.
- The death was violent or suspicious.
- The death was unnatural.
- The death may be due to an accident (whenever it occurred)
- The death may be due to self-neglect or neglect by others.
- The death may be due to an industrial disease or related to the deceased's employment.
- The death may be due to an abortion.
- The death occurred during an operation or before recovery from the effects of an anaesthetic.
- The death may be a suicide.
- The death occurred during or shortly after detention in police or prison custody.
- The death occurred while the deceased was subject to compulsory detention under the Mental Health Act.
- For any other concerning feature.

Appendix 2N - Whole Genome Sequence Testing Pathway Flow Chart

Following a Sudden Unexpected Death in Infant or Child (SUDIC)

Coroner's Office or Consultant Paediatrician/Clinician for child if coroner not involved, to inform parents at their initial contact, that a sample of tissue would be sent by the Pathologist to Genomics lab for DNA extraction and storage only (not testing at this point). Genetic studies may be undertaken on the sample, only if no cause of death identified on post mortem exam.

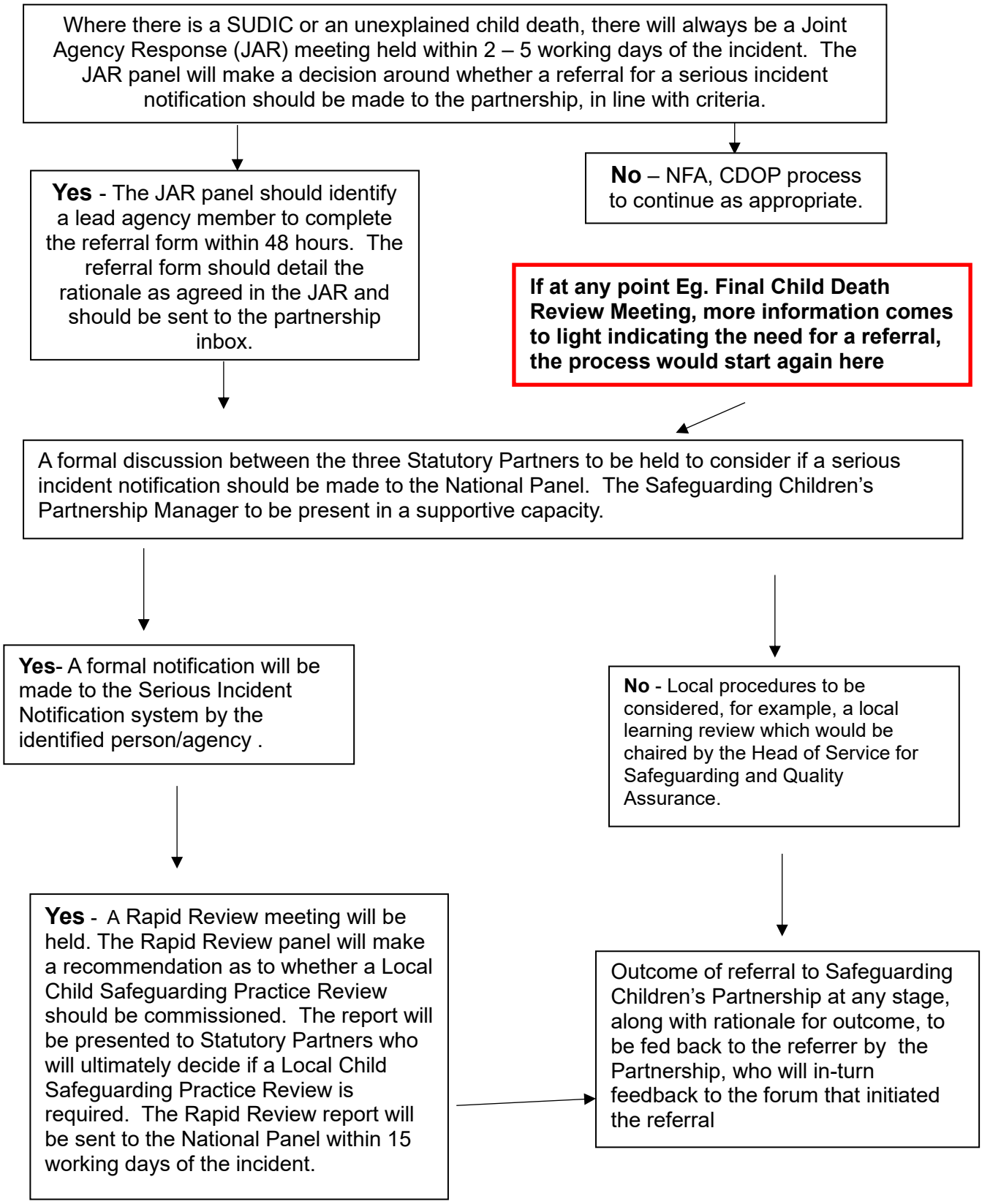
Only if no cause of death identified at Post Mortem exam, and DNA has been successfully extracted from the sample, a referral will be made by the Coroner's Office or consultant paediatrician/clinician for the child if coroner not involved, to the Genetics team for genetic studies to be undertaken, after debriefing the family and Designated Doctor for Child Deaths.

To facilitate the above, Full PM report to be forwarded by Coroner's Office to Pan Cheshire Child Death Overview Panel by Coroner's Office on receipt of the same from the Pathologist, for sharing with the relevant frontline Paediatrician caring for the child/family via the relevant area Designated Doctor for Child Deaths. The Coroner's Office should clarify if the report may be shared with the family.

The Coroner or the child's Consultant Paediatrician/Clinician if coroner not involved, after establishing with Genetics team that DNA sample is available for child, and after debriefing the family and Designated Doctor for Child Deaths, should refer to Genetics team for Whole Genome Sequence (WGS) test counselling and investigations, if criteria met i.e. no cause identified on post-mortem exam. During the debrief, Post Mortem report may be shared with the family if approved by the Coroner, but it should be made clear that the cause of death identified in the PM report may not be final and will only be determined at the conclusion of the Coroner's Inquest.

The Genetics team will then get in touch with parent(s), approximately 6 to 8 weeks following referral, to discuss further and obtain Informed Consent before testing is initiated. Results of WGS test and further management plan to be shared with the family and consultant paediatrician for the child, by Genetics team.

Appendix 2O – Child Safeguarding Practice Review (CSPR) Referral Process



Appendix 2P – 2wish Referral Form

Details required for 2wish referral:

Please return to support@2wish.org.uk

Date of referral:					
Name of deceased child/YP:					
Date of Birth:		**Date of death:**		**Age at time of death:**	
Where YP died:					
Brief details of death:					
Is it a historic death referral (more than 8 weeks):					
Name and contact no. of bereaved person/s:					
Address (if known): **Email:**					
Family details: **(e.g. siblings, parents together or separated)**					
Memory box given:		**Has verbal consent for referral been given:**			
Name, role and contact number of referrer:					
Has the bereaved person been informed about the CDOP?					
Any other relevant information: **(e.g. preferred language, known risk)**					